



Alternate Care Site Operational Plan



RiverCrest Community Center Alternate Care Site

ACS SURGE OPTIMIZATION PLAN

General Description

Chesapeake Regional Hospital's Emergency Management Committee has identified the need for an Alternative Care Site Operations Plan. This is to be a supplement to the existing health care system in managing the overwhelming number of patients in a natural biological threat (pandemic influenza, SARS, etc.) or mass casualty event.

Several reports, policies, and practices were used to synthesize the "best practice" activities outlined in this document. Surge capacity is the ability of a health care system to rapidly expand beyond normal services to meet the increased demand for qualified personnel, medical care and public health in the event of large-scale public health emergency or disaster.

As a modular facility, it can be set up quickly and easily dismantled once the surge has passed. The ACS is designed to be flexible, with a scope of care and service function that will serve as a Low-Acuity Patient Care.

To treat stable, low acuity patients with observational or palliative care to relieve hospital of patients who do not require acute treatments services or are too ill to benefit from the services.

Hospitals routinely deal with surge by going on bypass or rerouting patients to other hospitals. However, a bioterrorist event or a pandemic could severely stress the system and overwhelm these traditional procedures. There are two results that can be expected from the inadequacy of these routine surge capacity systems:

- Medical care and access to medical care might become seriously compromised.
- The quality or the standards of medical care might have to change to serve the greatest good.

The ACS is designed to meet these challenges by establishing a simple system that rapidly expands inpatient non-acute care facilities, integrates medical resources, and provides massive casualty management to a large population of patients.

There are several reasons for limiting the level of care at the ACS:

- The primary focus on limited treatment simplifies the logistics of setting up these centers and reduces the amount of supplies and equipment the District will need to cache.
- Hospitals have better access to the resources required to treat critically ill patients. These resources include cardiac monitors, oximeters, ventilators, free-flowing oxygen, intravenous pumps, and invasive monitoring equipment.
- Hospitals have better access to staff (i.e. respiratory therapists, critical care, emergency, surgical nurses, and physicians) experienced in resuscitation and care of critically ill patients. It is more efficient to concentrate these trained individuals in one location.
- Providing a selective level of care minimizes the ethical decisions healthcare providers would need

to make when only a limited supply of advanced care technology is available.

- This limited supply of equipment also eliminates healthcare providers' dependence on technology to provide mass care.
- A free-standing ACS facility faces a number of logistical barriers that prohibit the use of certain specialized hospital functions. For instance, an ACS established in a school gymnasium, community field house, or hospital cafeteria will likely not have necessary access to free-flowing oxygen, medical air to drive ventilators, or specialized electrical outlets required to provide certain critical care-level therapies and basic supportive care.
- Streamlining the care provided at the ACS will allow healthcare providers of various backgrounds to follow pre-established treatment guidelines.
- Recommending that an ACS be able to provide the same level of care that can be offered by a hospital places an unrealistic burden on the District to provide unlimited resources (i.e. money, equipment, and personnel) to an ACS.⁹
- In a mass casualty situation, healthcare workers will provide care to as many victims as possible, but individualized treatment plans may be rare or nonexistent. Advanced lifesaving technology and treatment options will likely either be unavailable or unfeasible due to a lack of specially trained medical personnel.

Standards of Care

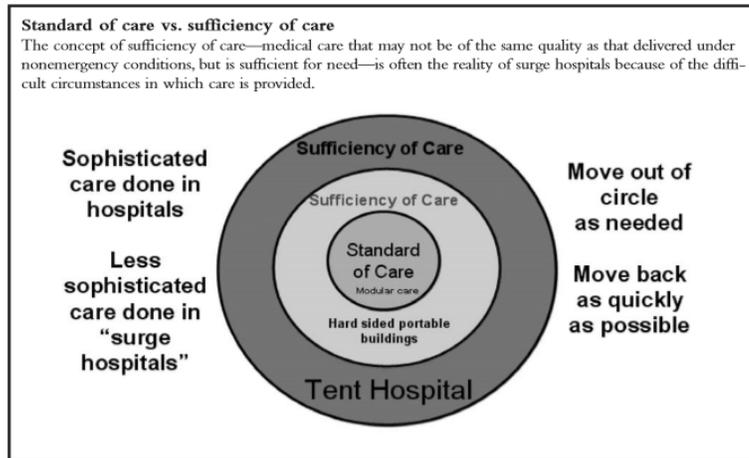
Nursing Position

In states of emergency, nurses may find themselves operating in environments demanding a balance between crisis standards of care and longstanding professional standards of care. Changes in the standard of care occur in circumstances when resources are limited, a clinician is practicing in an unusual setting or with unfamiliar patient care needs. In such situations, a utilitarian framework usually guides practice decisions and actions with special emphasis on transparency, protection of the public, and fair stewardship of resources.

This changing ethical framework in states of emergency shifts from “patient-centered practice” to considerations of care “to promote equality of person and equity in distribution of risks and benefits in society” (American Nurses Association, 2020). The ANA Code of Ethics obligates professional nurses to respect the dignity of every person in their care while also upholding the public good and collective human rights.

Registered nurses may be asked to delegate care to others, such as students, displaced staff, or volunteers. This will require a rapid assessment of the skills of the others available to assist in patient care. Nurses will continue to emphasize patient safety and appropriate delegation.

An increased reliance on a nurse's own or the collective accumulated competence may be needed, as the usual range of colleagues, experts or support services may not be available.



Essential decisions about allocation of resources must be made at an Incident Command level. The individual registered nurse should remain focused on patients and is responsible for giving the best possible care with available resources.

Changing Standards of Care

Ideally, the goal of a surge facility is to maintain high standards of care. In practice, however, treatment in an ACS may reach only the level of sufficiency of care due to challenging operational circumstances.

In a sufficiency-of-care facility, medical staff face challenges such as limited privacy for patient assessments, crowded conditions, and limited access to medical records and testing capabilities. In crisis situations, staff may be asked to practice outside of the scope of their usual expertise. Supplies may have to be reused and recycled. In some circumstances, resources may become completely depleted. Non-clinical individuals may be asked to provide basic patient care, such as hygiene and activities of daily living, that do not require medical expertise.

Other changes in operation at the crisis care capacity may include the following:

- Marked expansion in privileges
- Aggressive triaging based on potential clinical outcomes
- Conservation, reuse, or reallocation of critical supplies, such as oxygen, ventilators, medications, hemodynamic support, and allocation of blood products.
- Increase in patient-to-provider ratio
- Use of volunteers for some patient care
- Changes in palliative care
- Limitations in services and diagnostics versus clinical judgment replacing diagnostics
- Minimal documentation

When crisis standards of care prevail, there will be limitations on autonomous choices for both patients and practitioners regarding the allocation of remaining resources, but this does not permit actions that violate ethical norms.

ACS SURGE OPTIMIZATION PLAN

Functional Areas

ACS space requirements are based on the needs of the following functional areas:

- | | | |
|-----------------------------------|--------------------------------------------------|---------------------------------------------------------------------|
| - Communications | - distribution | - equipment |
| - Admissions/Registration | - Staff workstations | - Secure area (for patient valuables, deceased persons' belongings) |
| - Nursing subunits | - Support services (storage, bathrooms, utility) | - Temporary morgue |
| - Multipurpose staff area | - Food services | |
| - Pharmacy medication preparation | - Maintenance | |
| - Supply storage and | - Transportation dispatch and | |

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Accessibility



The RiverCrest Community Center will be utilized as the chosen site for the City of Chesapeake and Chesapeake Regional Hospital. The facility is located at 1001 River Walk Parkway, Chesapeake, VA 23320, 757-436-3100. This site is approximately 3 miles from the hospital with an estimate of 9-minute drive to and from.

This facility originally built in 1990 is a community center that is operational and is typically used and can be rented by the citizens of Chesapeake for use of parties and reunions. This facility has a gymnasium, kitchen, shower/locker room and secure staff areas. In the design of the ACS at Rivercrest we have accounted areas for employee access points with signage plans. In addition, the staff will have a designated lounge with appropriate social distancing requirements.

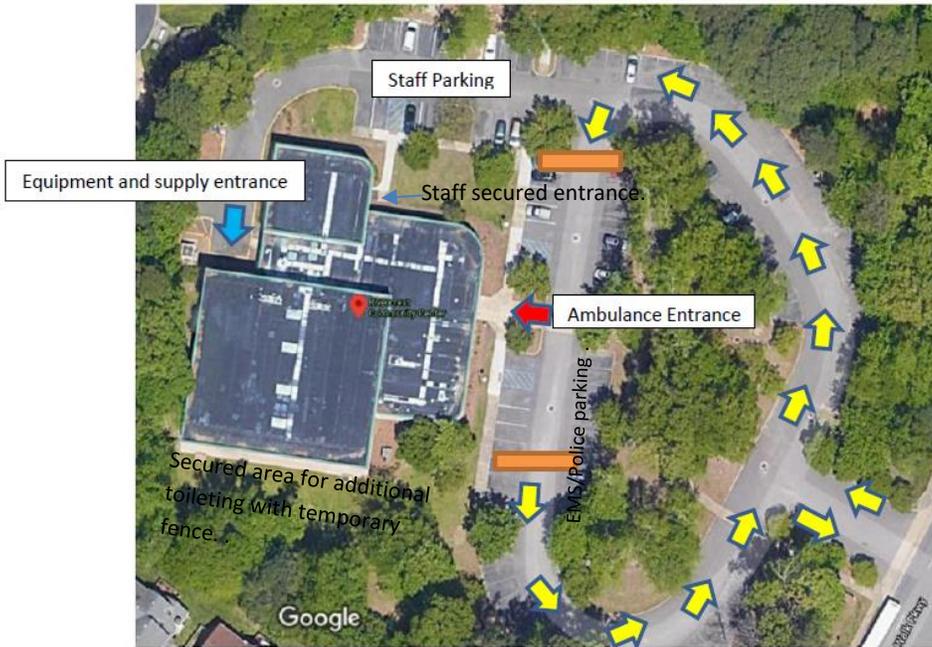
Access Points

- The admissions/registration area will be located in the main entrance with wheelchair/stretchers accessible entrance clearly labeled outside for EMS/Transport as the Pick/up and Drop Off Zone.
- The reception entrance must be clearly signed (in both English and Spanish) and should be visible from all approaches.

Parking

- The main car parking lot should be well lit and situated as close to the main entrance as possible.
- The main car parking lot should be used for patients, their relatives, and ACS staff.
- The curb by the front entrance of the building should be well marked with appropriate signage and should be designated as a loading zone for ambulances and buses that drop off and pick up patients.
- The parking lot must also contain designated parking areas for the following categories
 - Police vehicles
 - Logistical re-supply vehicles

- Ambulances that are not in use
- Taxis and private vehicles to pick up patients (including those with limited mobility)
- Family and other visitors
- A separate security patrolled parking lot should be reserved for ACS staff



KEY:

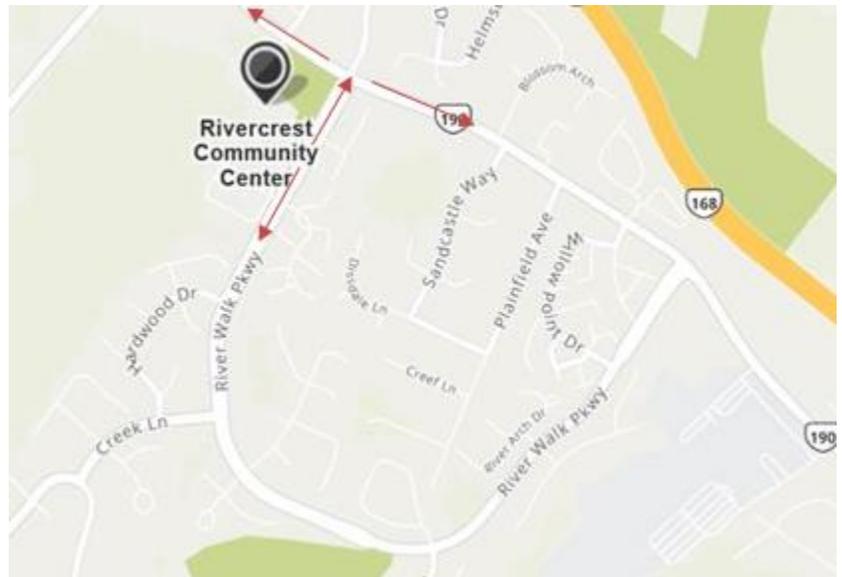
Yellow arrows – Traffic flow

Red arrow – Ambulance entrance

Blue arrow – Equipment and supply entrance

Orange blocks - Barricades

The Rivercrest Community Center is accessible to at least two roadways to provide continuous access in the event one becomes blocked or inaccessible. The City will provide interim and exterior signage for the ACS.



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Layout

Design Overview

- Ideally, the nursing subunits should be centrally located and easily accessible from the admissions area.
- Logistical support and communications offices should be arranged around the periphery of the nursing subunits or on the upper floors of the building. They should have access to the nursing subunits but should not impair the clinical functions of the ACS.
- Rooms must have adequate space for personnel and equipment to enter, exit, and maneuver.

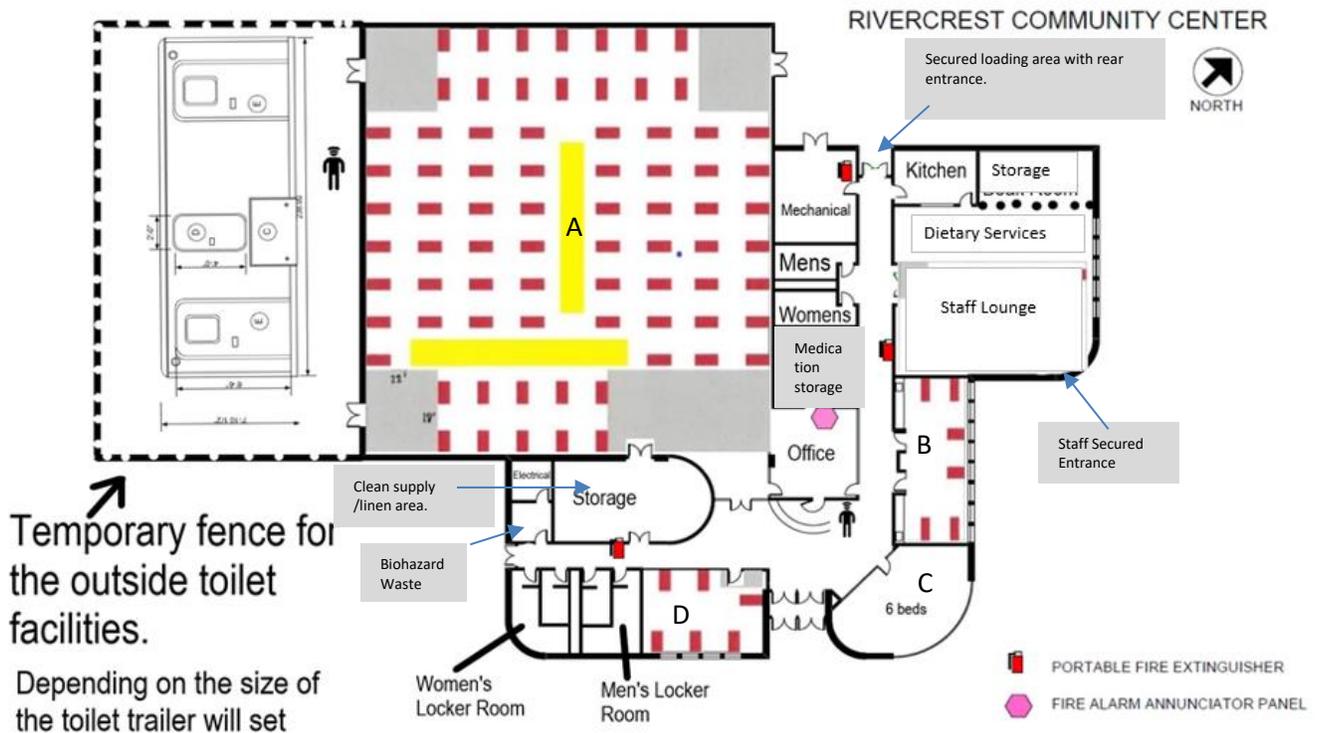
Traffic Patterns (Patients and Supplies)

- It is important to have rapid access to every area with a minimum of cross-traffic
- Close proximity between the admissions area and the nursing subunits will assist in managing high volume intake periods.
- Visitor and patient routes to public areas should avoid passing through clinical areas in order to assure patient privacy.
- All workstation and functional offices should be located where they do not impede patient flow or patient care.

Bed Spacing

There must be enough room to allow for routine care and patient/staff access

- The space between the head of each bed could conveniently be used to store disposable/non-disposable medical supplies. Modular plastic bins or similar storage solutions would be ideal



This facility proposes that we can have approximately 94-107 beds for non-COVID-19 non-monitored medical surgical patients.

Beds:

In patient care area (A) with the dimensions of 112' x 102'. We have allowed 18'x 22' areas at the exterior doors. There is an 18'x41' area to account for the interior entrance and storage areas. There is a 2' workable gap from cot sides to wall. There will be two areas within the sub units for hand sanitation stations or documentation areas that will not impede workflow. The stretchers/cots will be spaced 7' apart to account for patient privacy and healthcare work room. Privacy will be held by use of portable partitions. A grid system will be utilized to keep track of patient placement and safety. There are three other areas within the facility that can be tailored to the needs of the patient population. Rooms C & D can accommodate special consideration patients such as high fall risk or slightly confused patients, comfort care patients, isolation patients and or adapt to needs at that time. Room B has two sinks and two doors, it can be used as a procedural area or proposed set radiology area or an additional patient care area.

Medical Gas / Oxygen Provisions

- It is expensive and logistically complex to supply medical gases in any facility.
- If it is decided to provide medical gases (oxygen) at an ACS, which will most likely not have pre-existing internal medical gas lines, emergency planners should consider developing a multiple branch-line system which pipes oxygen directly to each nursing subunit. Portable cylinders may prove useful in establishing a temporary liquid oxygen manifold system. It is recommended that emergency planners involve a biomedical engineer in the setup of any such oxygen delivery system.

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Infrastructure

Doorways and Corridors

- Doors should be wide enough to easily accommodate wheelchairs and wheeled stretchers as well as any intravenous poles that may be attached.
- Corridors should be wide enough to allow two-way traffic of stretchers.
 - Corridors were verified via the site floor plans that the width meets standards for access.

Electricity Supply

- Must be surge protected to protect computers and electronic equipment
- Medical equipment and computers must have access to emergency power
- If not present on site, emergency generators and uninterruptible power supply (UPS) units should be included in the ACS supply list
- Ideally, would have specialized electrical outlets required to provide critical care-level medicine
 - Currently back-up portable generator access is what is there now. There is a full-building generator and switching equipment that is coming from Richmond and will be installed.

Heating and Air Conditioning

The Rivercrest Alternate Care Site has HVAC capacities that are enough to ensure that all areas of the site are maintained at an appropriate level. This includes maintaining temperature to ensure patient comfort, pharmaceutical storage guidelines, and other supply and equipment needs. This HVAC system has

appropriate generator backup which will be able to sustain operations in the event of unexpected power loss.

Lighting

- Clinical areas must have adequate artificial lighting in order to perform procedures, assessments, and other forms of direct patient care.
- Natural sunlight can minimize patient and staff disorientation.
 - The gym is well lit and the rooms B, C, & D have windows and natural sunlight.

Floor Coverings

- Must be durable, non-slip (no carpeting) , and impermeable to water and bodily fluids
 - The flooring in the gym will have to be returned to normal state as before the ACS. This can be done by means of protective coverings or refinishing afterwards.

Hand Wash Facilities

- There is running city water capability in the two sets of male and female bathrooms, locker rooms and kitchen area. The City can work with CRH to provide lightweight, plastic portable units.

Refrigeration

- The facility must have onsite refrigeration capabilities, or it should have an electrical supply sufficient to power temporary refrigeration units. The facility has one refrigerator present in the kitchen area.

Storage Capacities

- Must have space sufficient to unload and distribute the incoming supply cache
- Ideally, the facility should have a secure loading zone area which can accept large scale shipments of medical supplies, equipment, and food
 - Areas have been planned for secure loading zone areas to the rear of the building and marked on the site map.
- Must have space sufficient to temporarily store bio-hazardous waste.
 - The storage area can be utilized as a bio-hazard waste area that can be closed off and safely secured for maximum safety.
 - The storage area off the gym can be used as a clean supply/linen area.

Life Safety

- The facility is equipped with sprinkler system and has fire extinguishers available per code.

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Site Security

Many facilities can be secured with adequate law enforcement personnel. However, security personnel may be in short supply during a pandemic or bioterrorist attack scenario for numerous reasons. Choosing a building which is easily securable may reduce the number of security personnel required and/or enhance security performance.

The following site characteristics would be helpful:

- Secured entrances and exits
- Adequate outdoor flood lighting
- In addition to the standard outer security perimeter, a building which can easily accommodate an inner security perimeter would be useful in separating the nursing subunits and administrative sections from the admissions/registration area
- The ability to lockdown the facility

The Rivercrest site is already equipped with security surveillance of the campus. There will be a City “site manager” that will have knowledge and access to the facility and can assist in need of a lockdown procedure.

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Communication

Communications are a vital component to any properly functioning emergency public health system.

The City of Chesapeake operates with the following means of communication:

Health Alert Network (HAN)

One such integrated communications approach is the Health Alert Network (HAN), which has been developed by the Centers for Disease Control and Prevention (CDC): “HAN is a nationwide program that establishes the communications, information, distance learning, and organizational infrastructure for a new level of defense against health threats.”²¹

Emergency Operations Center (EOC)

The City of Chesapeake is responsible for activating and maintaining the EOC, and Chesapeake Regional Healthcare participates as a partner with the City’s Unified Command when needed.

EOC Joint Information Center (JIC)

Chesapeake Regional Healthcare provides a PIO to work with the City of Chesapeake’s JIC.

WebEOC

The Emergency Management Coordinator for Chesapeake Regional Healthcare has access to the City of Chesapeake’s WebEOC platform. WebEOC allows for resource requests, activity reporting, and other information to be coordinated through one platform to track requests and information.

Everbridge

The Everbridge system is used to inform the public during a major crisis or emergency. The system delivers simultaneous public alerts via the following methods:

- Phone
- Text
- Email
- Pager

This system can alert the public with real-time updates, instructions on where to go, what to do, or what not to do, who to contact and other important information.

It is important to have a pre-planned communications structure in place before the ACS activation decision is made. Ideally there will be a unified command communication system that can coordinate not only the activation of an ACS (or multiple ACSs) but also enable emergency public health management to apply consistent and responsive approaches to care in a fast moving and constantly shifting environment.

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Risk- Communication Considerations

Emergency planners should consider the following risk communication categories as a supplement to effective ACS operations:

Risk Communication: Actively informs the public about the health emergency “...first, to provide knowledge and understanding of the situation at hand, second to enhance trust and credibility between the public and responders, and third to encourage constructive dialogue”

- Provides the public with appropriate action guidelines (if any such action is deemed necessary)
- Minimizes confusion and anxiety
- Limits the burden placed on health systems by those who will seek out such information on their own and thus increase the surge capacity need
- Public information officers (PIOs) should direct non-critical patients away from hospitals whenever possible
- Health Information Communication
- Answers specific questions and concerns through call centers and hotlines
- Minimizes the calls received elsewhere in the public health system

It is of paramount importance that all emergency communications with the public be accurate, frank, and current. Indeed, the public should be viewed as a partner and ally during a health emergency rather than “the problem to be managed.”²⁴ Any public perception that emergency communications are inaccurate, vague, or out of date will not only be counterproductive to the goals of risk communication theory but may also add to the general burden on health systems by

creating an atmosphere of mistrust:

- Rumors and hearsay will fill perceived information vacuums
- The public may become uncooperative, adversarial, confrontational, or even mutinous

Psychological stress associated with a public health emergency will likely have a significant impact on how the public interprets and comprehends communications. There are four major risk communication theories which define and attempt to overcome specific psychological obstacles which may be expected in a public health emergency:

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Communications Reliability

Communications failures can adversely affect the overall success of the ACS. Therefore, any emergency communications system of which the ACS is a component should seek to incorporate redundant (backup) capacities. Emergency planners may wish to consider some of the following possibilities in establishing the system:

- Dedicated land lines
 - Requires a pre-selected ACS in order to install the proper wiring
 - Secure communication
- Cellular phones
 - Highly mobile
 - Battery life dependent
 - Cellular network dependent (may be overloaded during a crisis)
 - Semi-secure communication
- Handheld 2-way radios
 - Highly mobile
 - Battery life dependent
 - Non-secure communication
- FM/AM radio broadcasting
 - One-way communication capacity
 - Widespread dissemination of information
 - Non-secure communication
- Local HAM operators
 - Two-way communication capacity
 - Non-secure communication

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Threats to Patient Flow and Optimal ACS Performance

The ability to recruit staff depends on the scale and geographic range of the public health emergency. The more geographically widespread the event, the more difficult it will be to find available medical personnel. The pandemic scenario, therefore, is very troubling. Staffing the ACS with medical personnel from the afflicted area will be a challenge for several reasons:

- Local medical personnel will already likely be inundated by patients in their routine medical settings
- Normally available local medical personnel will not necessarily make themselves available in the event of a bioterrorist attack or pandemic outbreak, fearing for their own safety and/or the safety of their families
- The locally afflicted environment may be chaotic and normal systems may not function

It must then be assumed that most ACS staff will have to come from sources outside the afflicted area. However, in a pandemic scenario, outside assistance will not likely be forthcoming.

Finding an adequate number of medical professionals to staff an ACS requires creative preplanning. There are several methods which can provide ACS staff:

Regional Hospital Alliance – “The Pot-Luck Approach”

- Each participating hospital pre-designates a small contribution of medical personnel which in aggregate provides an ACS with a full level of staffing.³⁹ The alliance must be organized to balance the number and ratio of required medical personnel categories: physicians, nurses, social workers, administrators, etc. The small number of staff required from each participating hospital will minimize impact on normal functionality.

Emergency Systems for Advance Registration of Volunteer Health Professionals (ESAR-VHP)

- Helps to address the issues of medical personnel verification and credentialing.
- Provides a simple way of identifying large numbers of properly credentialed medical personnel in a given region.

Mutual Aid Agreements

- Chesapeake Regional Healthcare has existing Mutual Aid Agreements, both written and verbal, with local, state, and federal partners.

Emergency Credentialing/Licensure of Volunteers and Non-Affiliated Professionals

- Chesapeake Regional Healthcare has established policies in place for how to address volunteers or non-affiliated professionals during times of emergency need.

Medical Reserve Corp (MRC)

- The Chesapeake MRC has volunteers who may be available to help staff an Alternate Care Site. MRC volunteers are often retired medical professionals who would be able to assist with screenings, evaluations, care, and other needs within an Alternate Care Site.
 - Communications have been established to utilize these staff members if the need arises.

Faith-Based Community and Community Health Workers

- May provide a dedicated source of volunteers

Orientation and training is necessary for staff to operate effectively within the ACS. The effectiveness of this training will play a significant role in the overall success of the ACS. At the very least, all staff members should receive some basic training which covers the mission of the ACS, a building orientation and walk-through, the command structure and organization breakdown, and standard ACS operating procedures and any non-routine specifications therein. Ideally staff should receive this training before their first shift, but it is possible that an abbreviated or just-in-time training may become necessary.

Best Practices:

Job Action Sheets

Job Action Sheets are a simple method for assigning and identifying roles and responsibilities for all personnel. They are straightforward job description checklists outlining critical activities for a specific job position. Disaster situations are unpredictable and extremely variable.

These aspects, coupled with staff turnover, excitement, anxiety, and feelings of urgency or haste may confuse even experienced personnel. Roles are easily forgotten in the urgency of the moment. Job Action Sheets are used in addition to the extemporaneous training to teach staff what to do; when to do it, and to whom they report. To ease the burden of memorizing protocols, each staff member is issued a sheet that prioritizes a detailed description of the critical actions necessary for successful performance.

CRH has worked with the Education department to cover a plan for oncoming staff. Job action sheets have been designed and a brief orientation has been established.

As a minimum, training must cover the following points:

- Information on the agent and treatment modalities
- Personal protective measures, including infection control measures (handling and disposing of infectious waste, agent-specific transmission prevention measures, etc.)
- Standard operating procedures
- Standard reporting procedures
- Response to outside requests for information
- Patient confidentiality

- At the end of the first 12-hour ACS shift, new staff may not have the opportunity to attend a formal orientation for various reasons (ie. the high workload, the chaotic situation, etc). In this case, it is suggested that the relief staff arrive 30 minutes early in order to shadow those staff whose shifts are about to end, thereby transferring as much on the job training as possible before taking over full responsibilities.

- Given the novelty of the ACS setting and its unique circumstances, many of the skills and know-how developed by the first staffing shift will be cutting edge and possibly exemplary. These skills will be invaluable to the staff sent to replace the first shift. Effective knowledge transfer between shifts, especially between the first and second 12 hours of operation, will be critical

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Patient Distribution

Patients of either a bioterrorist attack or a pandemic will first arrive for triage at CRH Hospital ED. The hospital ED will perform the work-up and then notify the nursing supervisor who will then contact the incident commander which will determine where these patients will be admitted (low-acuity ACS or Hospital). The Command Center team will make decisions on patient placement to be carried out. The Command Center will alert the ACS of the number of incoming patients expected and other pertinent logistics such as how many patients require transfer by stretcher versus wheelchair.

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Admissions Procedure

Incoming ACS patients should be directed to the admissions/registration area. The Patient Care Coordinator (PCC) should rapidly evaluate and assign a nursing subunit bed to each patient, who should be given an admissions packet that includes preprinted standing admission orders.⁴⁷

Paper Based Documentation

Patient Documentation

A functional medical record must be established for every individual who is treated at the ACS. This record accompanies each patient throughout his/her stay and is available to the medical staff as needed for documenting the treatment provided and the patient's response. All records must be complete, legible, and thorough.

Initially, each patient will arrive at the ACS as an established patient transferring from the ED. In the ED, the patient is registered as normal with current demographics and insurance information. When the admit decision is made and the patient is verified, they are a candidate for the ACS, the Incident will assist with transfer and work with the ACS for bed arrangements. The patient will have an arm band for patient identification, patient transfer summary and labels to be sent with the patient. The patient will be placed in a "virtual bed" in the bed planning board to their assigned bed at the ACS for tracking. In addition, this will serve as their active chart that documents can be scanned into and results can feed into. Upon arrival to the ACS, additional components of the patient's medical record will be converted to paper-based charting and physician ordering. Admitting paperwork will include patient labels with MRN to include on all paper forms for post-processing into the electronic medical record.

A basic admission package of paperwork should be minimally composed of pre-printed standing admission orders, medical history and physical, multidisciplinary progress notes, and nursing flowsheets (for documenting vital signs, intake and output [I&O], activities of daily living [ADL], etc.). Existing Chesapeake Regional downtime forms will serve as the standard for documentation.

When operating under crisis standards of care, nursing documentation requirements should be scaled down as much as possible and charting by exception is highly recommended. Suggested documentation frequency is as follows:

- Physical assessment (head to toe) every shift
- Vital signs standard every shift
- Intake/output standard every shift
- Rounding every three hours
- Narrative nursing progress notes to capture dynamic events and changes in any patient condition.

The patient will then be assigned to a bed on their assigned nursing subunits. Upon arrival at the nursing subunit, a physician will complete and customize each patient's standing admission orders based on his or her assessment.

Standard inpatient procedures will prevail but will follow a more streamlined and scaled down approach consistent with the limited care options available at the ACS. Medical clerical personnel in each nursing subunit will process the physician's standing orders, while the RN will verify implementation. Nurses will complete an admission assessment and initiate the plan of care for each patient.

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Plan of Care

A standardized plan of care should be developed in advance for each virus likely to be encountered. The following plan of care / agent matrix provides several suggested biological agent specific therapies:

In the event of an influenza pandemic, it is suggested that the ACS plan of care follow a supportive or palliative therapy, which may include the provision of IV fluids and limited medical intervention.

In all cases, plan of care options should be developed and carried out under the direct supervision of a physician.

Patient Criteria		
<u>Rivercrest/LSC/JOC Cots</u>	<u>JOC Bays</u>	<u>CRH</u>
MEWS Score <2 and full code	MEWS Score <3 and full code	MEWS Score >3
Simple intravenous rehydration	Telemetry monitoring	Antepartum with any other diagnosis
Intravenous antibiotics able to be administered with Dial-a-Flow/gtt	Infectious disease requiring strict isolation (no cohorting)	Intravenous antibiotics requiring Alaris pump.
Infectious disease, site-specific <ul style="list-style-type: none"> • In urine • In wound 	Requirement for HOB elevation >30 degrees <ul style="list-style-type: none"> • NGT • Tube feedings 	Infection disease requiring negative pressure isolation.

Pain control Nausea/vomiting control	Post-op requiring intervention	PCA requirement
Simple post-op <ul style="list-style-type: none"> No therapy PO pain control 	Non-operative fractures	Post-interventions <ul style="list-style-type: none"> Neuro (up to 24 hr. after discontinuing TPA) Cardiac Cath
Skilled wound care	Total care patient	Heparin infusion
Low acuity respiratory distress <ul style="list-style-type: none"> May be able to cohort influenza/pneumonia Cannot be COVID rule-out 	Moderate acuity respiratory distress <ul style="list-style-type: none"> >2L/O2 BiPAP CPAP High Flow Nebulizer Tx 	High acuity respiratory distress
SQ hyperglycemia mgmt.	Moderate falls risk	Blood/blood products transfusions
Peritoneal dialysis		IV Glucommander
Comfort measures/hospice		STEMI/NSTEMI
Ambulatory <ul style="list-style-type: none"> Self 1x assist Low falls risk 		Rule-out chest pain
Weight limit of cots/stretchers 350lbs max.		Tracheostomies
		Pressure injury (any stage or potential)
		High falls risk requiring AvaSys
		Hemodialysis
		Acute psychiatric emergency/suicidal ideation
		Intravenous infusion requiring Alaris pump.

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Guidelines for Patient Discharge or Death

There must be a pre-established criterion used to guide patient transfer and discharge decisions in order to maximize the number of ACS beds available for additional admissions.

- It should be noted that the need for patient discharge procedures is situation-dependent. The ACS may administer palliative rather than curative care in the case that very few patients are expected to survive to discharge status.

Where discharge is appropriate, case managers and social workers will assist in planning for at home

assistance and care. This will include referrals to psychological services and human relief services as well as necessary follow-up. Patients should receive pre-printed agent-specific discharge instructions along with a starter pack of any agent-specific medicines they may still require.

The deceased will be transferred to the ACS temporary morgue, which is responsible for tagging the remains, processing the records, and securing any personal effects. The appropriate notification to funeral homes will be conducted. The patient will not return to CRH morgue. In this event that this is needed at the Rivercrest Site, a refrigeration truck will be needed to serve as a dedicated temporary morgue until transport can be arranged.

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Unit Functions

Records/Planning Section

- Admissions/Registration
- Staffs the admission/registration area with a patient care coordinator (PCC)
- The function of the PCC is critical, similar to that of a nursing supervisor operating in a traditional hospital setting.
- The PCC will be located in the Records/Planning Section but has support functions across the ACS.

The PCC maintains awareness of nursing staff and bed availability and directs patients to the nursing subunits accordingly.

- Manages all paperwork generated in the ACS
- Keeps track of all inpatients, including walk-ins who do not arrive from a hospital's ED or the NEHC.
- Responsible for keeping patient status up to date
 - Patient registration
 - Patient treatment
 - Patient disposition
- Labor Pool
 - If staffing permits, a Labor Pool Unit Leader may be appointed
 - Responsible for keeping staffing status up to date
 - Maintains a staffing log which records the presence or absence of all available ACS personnel, including spontaneous volunteers
- Internal Patient Transportation
 - Transports patients from registration/admission area to their assigned nursing subunit bed.
 - Transports the deceased from their assigned nursing subunit bed to the temporary morgue
 - May also need to assist with bed/patient transport in other capacities due to unforeseen logistics.

Medical Operations Section

Directed by a physician, the Medical Operations Section is responsible for all clinical areas of the ACS and every patient under its care. Responsible for maintaining strict infection control procedures and the overall sanitary condition of the ACS to protect staff, visitors, and patients.

- Pharmacy Services
- Forecasts, orders, dispenses, stores, and maintains accountability of the pharmaceuticals needed to

operate the ACS

-

Radiology Services

- VDH approval has been authorized if the need arises.
 - EPIC and IT connectivity, this will drive what equipment is possible
 - Portable x ray unit
 - If no or poor connectivity will need constant carrier service
 - Mobile lead walls and lead aprons
 - 12x12 space if making an x ray room (corner, exterior wall best)
- Family Services: No visitation policy in effect due to pandemic.
- Temporary Morgue
 - Records personal data of the deceased
 - Tags the remains
 - Inventories and secures personal effects
 - Arranges for transfer to mortuary facility
 - Temporarily stores remains until they can be sent to mortuary facility

Supply/Logistics Section

Responsible for all ACS services and support, including obtaining and maintaining the facility, equipment, and supplies.

- Maintenance
- Procures, repairs, tracks, and maintains all equipment and the physical plant of the ACS
- Materials Supply
- Forecasts, orders, stores, and maintains accountability of equipment and supplies necessary for ACS operation in coordination with Resource Transportation.
- Resource Transportation
- Moves all supplies and equipment within the ACS
- Delivers supplies from the external facility

Food Service

The Chesapeake Health Department Division of Environmental Health has approved the following plan for the preparation and distribution of meals for the Chesapeake Regional Healthcare Alternate Care Site:

- All food will be prepared and packaged at Chesapeake Regional Medical Center or other prior inspected and permitted kitchen.
 - Food will be packaged in individual cardboard box style packaging, and then individually wrapped to protect the contents.
 - Cold food will be placed in a Cambro box with ice sheets to ensure the food remains cold during transport.
 - Hot food will be transported to ensure that it arrives at the Alternate Care Site to comply with temperature guidelines
 - All food items will be delivered within 2 hours of preparation.
 - All food items must be eaten, cooled to 41 degrees, or reheated to 160 degrees within 4 hours of preparation.
 - Food preparation area must be separate from patient areas
- Housekeeping
 - Cleans and disinfects the ACS

- May coordinate cleaning procedures with Medical Operations

Finance Section

- The creation of the Finance Section is at the discretion of the ACS Administrator if sufficient resources are available.
- Cost Accounting
 - To accurately account for the costs of running the ACS in order to prepare for later impact analysis and reimbursements

Staffing

General Requirements

The nature of the medical needs and shortage of staff in an emergency incident may make traditional role delineation impractical. Therefore, divisions of responsibilities for various aspects of patient care and program administration will be based on knowledge, experience, special talents, and to some extent, interests of individual staff members. In this way, each staff member's particular abilities will be fully used and operations will run more smoothly. Nonmedical personnel, such as clerks and volunteers, will be engaged extensively throughout the ACS to lessen the burden on the clinical staff. Volunteers will be used is available; however, the ACS design is predicated on the assumption that they will not be available.

Suggested minimum staffing per 12-hour shift per 48 patients follows:

- One physician
- One midlevel provider
- Six Registered Nurses (RNs) or mix of RNs and licensed practical nurses (LPNs)
- Four unlicensed assistive personnel/Emergency Medical Technicians (EMTs)
- Two clerks/secretaries
- One respiratory therapist
- One case manager
- Two housekeepers

The minimum number staff providing direct patient care on the 48-bed nursing subunit per 12-hour shift is 12, which includes all providers, nurses, and unlicensed assistive personnel. The physician will be assigned the entire subunit, while the nursing staff will operate in a team approach. Nursing teams comprised of RNs and LPNs must account for RN oversight of all LPN activity. The RN will be responsible for assessment documentation and care planning. Members of the patient care team will have tasks assigned that are consistent with their scope of practice.

Nurses are responsible for nursing care of patients, including assessment planning and evaluation of response to medical interventions. They must show evidence of the knowledge and skills necessary to deliver the care required by patients admitted to the ACS.

Medical Equipment and Supplies

General Requirements

Administrative Consumables for 50 Bed Nursing Subunit

Alternate Care Site Supply List Quantities per 50 patients									
ADLs	Qty	Pharmaceutical	Qty	Care Delivery	Qty	Nursing	Qty	Dietary	Qty
ReadyBath packs	5/pt q day	Alcohol pads	2-4 boxes per 24 hrs	Land line	3	Work stations/tables	6	8 oz cups	2/ pt/ day
Toothbrushes	50/ day	Bacitracin	1 box/ wk	Fax machine	1	Chairs	12	16 oz cups	2/ pt/ day
Toothpaste	50/ day	Medicine cups	3/pt/d ay	Cellular phone chargers	6	Clipboards	1/ staff	Cup lids	4/pt/ day
Oral care swabs	10/ day	Syringes , luer lock • 3ml • 5ml • 10ml	100/d ay each size	Flashlights	6	Pens/pencils	2/ staff	Straws	4/pt/ day
Soap	25/ pt q day	Irrigation/ Toomey syringe (60 ml)	25/ wk	Batteries,D	18	Gloves (S,M,L), nitrile powder-free	6 boxes/day	Coffee	
Urinals	40/day	Insulin syringes	120/d ay	Cots	52	Splash-resistant gowns	3/ staff q day	Clear liquids	
Bedpans	40/day	D50	5/ wk	Flat sheets x2 each cot	150	Surgical face masks	36/ day	Juice (fast-acting carbohydrate)	
Commode s		Silent Knight pill crusher	1	Blanket x 2 each cot	150	Goggles/ eye shields	6 boxes/day	Snacks (graham crackers, peanut butter, applesauce)	

								, pudding packs, saltines, dry cereal, instant oatmeal)	
Emesis bags	100/wk	Pill crusher bags	2 packs/wk	Pillows	75	Hand soap	1 bottle every station/day	Ice	
Stretch briefs	20/day	IVF 0.9NS	75/day	Housekeeping cart	2	Hand sanitizer	1 bottle every station/day	Diet signs (NPO, diabetic, etc.)	1/each pt
Denture cups	20	IVF 0.45NS	50/day	IV poles/string to hang overhead	50	Paper towels	25 rolls/day	Microwave	1
Texas catheter <ul style="list-style-type: none"> • Small • Standard 	20	IVF D5LR	75/day	Curtain dividers	25	Sharps disposal	1	Utensils	
Chux pads	3/pt qday	IVF D5NS	50/day	Wheelchairs	2	Tape	2 rolls/wk		
Toilet paper	25 rolls/day	IVF LR	75/day	IV tubing w/ standard macrodrip for adults	250/wk	Paper clips	2 boxes/wk		
Adult briefs	1 case of 72 per week	Nebulizer kit	15/wk	Dial-a-flow meters	250/wk	Paper punch	2		
Facial tissues	1 box per pt q day	Needles 25g x 1in	10/pt/day	IV catheter start kits (20g, 22g)	75 for every 2	Patient charts	1 per pt		

					day s				
Sanitary pads	1 pack/day	Needles 21gx1in	10/pt/day	Phlebotomy kits <ul style="list-style-type: none"> • Butterfly needles 24g • Vacutainers • Lab tubes • Biohazard bags 	2 per patient q24 hours; 2 each kind per patient; 2 bags per pt q24 hours	Blank order sheets			
Skin protectant/barrier cream	10/day	Blunt tip needles	10/pt/day	Urine specimen container	50/day	Progress note sheets			
Slipper socks	50/day	Filter needles	1 box/wk	Postmortem bags	5	Nursing flowsheets			
Foley catheter statlocks	100/wk	NS Irrigation Solution 1L bottle	10/day	Coban tape 4"	1/day	Admission H&P sheets			
Provon Foley wipes	100/wk	Sterile Water Irrigation Solution 1L bottle	10/day	Kerlix gauze rolls	5/day	Death packets	5		

Towels	75/ day			Gauze <ul style="list-style-type: none"> • 4x4 (sterile and non-sterile) • 2x2 	400 /day	Advance Care Plans			
Washcloths	75/ day	Saline flushes	5/p t/ da y	ABD pads 8x10	5/pt / day	Sani Cloth/PD I wipes	2/ day		
		PD fluid	3/ da y	Paper tape	5 roll s/ day	AED/ Defibrilla tor	2		
		Atrauma tic clamps	2	Micropore tape	5 roll s/ day	AED/ Defibrilla tor pads	2 sets		
		PD minicap s	3/ da y	Mepilex border sacrum	5/ day	Infectiou s waste bags (red bags)			
		Hanging scale	1	Telfa non- adhesive dressing	5/ pt/ day	Trash bags			
		PD infusion sets	2/d ay	Tegaderm bioocclusive	5/pt / day	Trash cans			
		Chlorhe xidine swabs	1 bo x/ da y	Foley catheter kits 16g	100 /wk	Soiled linen bags			
				Catheter Foley coude 18g	10	Fluid spill kits	5/ day		
				Water soluble lubricant	1 box /wk	Stapler	3		
				Soft wrist restraints	1 case	Staples	6 boxe s/ wk		
				Glucometers	2				

				Glucometer test strips	2 bottles/wk				
				Glucometer control solution	2 bottles				
				Lancets	120/day				
				Blood pressure cuffs	50				
				Thermometers	4				
				Thermometer probe covers	4 boxes/day				
				Pulse oximeters	10				
				AMBU bags 1600ml reservoir	2				
				Oxygen tanks <ul style="list-style-type: none"> • “E” cylinder (700 L) • “H” cylinder (7000 L) 	E – 4 H - 10				
				Nasal cannula	40				
				Simple face mask	10				
				Non-rebreather mask	10				
				Portable suction unit and battery	2				
				Yankeur suction	10				

			Suction tubing connector	10				
			Suction tubing, 10F	10				
			Aerobic culture tube	10				
			Anaerobic culture tube	10				
			Sterile gloves • Sizes 6-9	4 pr/ staff/ day				
			Graduated cylinders	50/ day				
			Incentive spirometers	20				
			4-way stopcocks	15				
			Ice packs	15				
			Walkers	3				
			Gait belts	25				
			Call bell for patients	50				
			Universal adapters	15				
			Biopatch	5				
			Patient gowns	75/ day				
			Warm packs	25				

Oxygen and Respiratory-Related Equipment Considerations for 50 Bed Nursing Subunit

Item Description	Quantity
Bag-Valve-Mask w/adult and peds masks—adult 1600 ml reservoir	1
Cascade gauge for oxygen cylinders	14
Catheters, suction	20
Connector, 5 in 1	8
Cylinder holders for E Cylinder oxygen tanks	4
Mask, oxygen—nonrebreather, pediatric	10
Mask, oxygen—nonrebreather, adult	20
Nasal cannula, adult	40
Nasal cannula, pediatric	10
Regulator, Oxygen (Flow meter)	14
Suction unit—Collection System	2

Suction unit—Portable	1
Suction unit Battery	1
Tank, Oxygen "E" cylinder (700 L O ₂)	4
Tank, Oxygen "H" cylinder (7000 L O ₂)	10
Tubing, oxygen—with connector	40
Tubing—suction, connector	10
Tubing, suction, 10F	10
Wrench, Oxygen tank	2
Yankaur Suction Catheter	10
Intubation equipment with oral airways/ET tubes; adult & peds	1 set
Ventilators	1

Office Supplies to consider for
Planning:

- Black ballpoint Pens
- Red ballpoint
- Stapler
- Staples
- Tape
- Tape dispenser
- Paper clips
- Paper punch (3- or 5-hole based on chart holders)
- Chart holders/Clip boards
- File Folders—letter size, variety of colors
- Name bands for Identification and Allergies
- Batteries—9V
- Batteries—AA
- Batteries—C
- Batteries—D
- Clipboards
- Chalk or white boards
- Dry-erase markers Chalk
- Trashcans and liners
- Flashlights
- Plastic bags for patient valuables
- Floor lamps
- Table lamps
- Lightbulbs

- Plain paper
- Filing cabinets—rolling
- Black permanent markers
- Yellow highlighter markers
- Time cards
- Generic sign-in, sign-out forms
- Pre-printed admission Order forms
- Blank physician order forms
- Multidisciplinary progress notes
- Nursing flowsheets
- Admission history & physical forms (include area for Nrsg Hx)
- Death certificates/Death packets