Crisis Care Continuum Guidelines

COVID-19 Surge Plan

<u>Executive Summary</u>

Purpose:

To provide high level planning information related to an expected surge of patients with COVID-19. All documents related to surge planning are in "working draft" form since the COVID-19 pandemic will require CCRMC to be nimble, respond to unpredictable changes, and change our strategy as the situation evolves.

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Updated: 1/5/2021

Overview

1. Background
   a. COVID-19 was declared a global pandemic on March 11, 2020. This disease is caused by a novel virus in the coronavirus family named "SARS-CoV-2".
   b. COVID-19 has been spreading through the United States since January 2020 and is predicted to cause large clusters of outbreaks that present to healthcare systems as "surges" of patients.
   c. The State of California has asked all acute care facilities to prepare for a 40%+ increase in patient beds in each facility if possible.
   d. COVID-19 patients have potential to become critically ill and often require mechanical ventilation.
2. Process
   a. This plan was developed with the input from leaders and front-line workers from throughout the organization.
   b. This plan will continue to evolve as the situation evolves.
   c. The second revision of this plan includes lessons learned from increases in cases experienced during the summer months of 2020 in preparation for projected increases in the fall and winter.
   d. This plan uses colors (Green, Yellow, Orange, Red) to identify a common point of reference for the planning of events in a stepwise fashion.
   e. Additions to this plan will continue in this framework so that there is a system wide understanding of what happens when CCRMC is "in orange," for example.
   f. Surge status will be designated by the Incident Command Center and communicated daily with staff.
   g. Command Center designates surge level based on the following triggers:
      i. COVID-19 census and patient acuity
      ii. Isolation room occupancy
      iii. Bed availability
   h. Each surge level identifies:
      i. Changes to workflows
      ii. Changes to staffing
      iii. Preparation activities for the next level

Executive Summary - Status GREEN

1. Overview
   a. Green status connotes a low COVID-19 volume state where there are sporadic increases and decreases in the numbers of COVID-19 patients
   b. Green status is considered "status quo" and does not necessitate major alterations to workflows
   c. Use existing equipment, staff, and supplies

2. Patients
   a. COVID-19 patients are cared for on units based on care level needs (ie Intensive Care Unit (ICU) level on ICU unit).
   b. COVID-19 patients will be placed in negative isolation pressure rooms located on the same units.
   c. 4A (Med/Surg/Telemetry) opened as needed for additional capacity and/or to cohort COVID-19 patients.
   d. All Emergency Department (ED) and inpatients are placed in negative pressure rooms or private rooms with HEPA filters.

3. Staffing
   a. No specific staffing changes are required
   b. Isolation and quarantine guidelines for infected or exposed staff are in place.
   c. A plan to implement Center for Disease Control (CDC) and California Department of Public Health (CDPH) strategies to maintain staffing during times of staffing shortages is in place.
   d. Onboarding temporary agency staff to maintain adequate staffing

4. Important Activities
   a. Acquire and maintain at least 60 days on hand of all Personal Protective Device (PPE) and cleaning supplies
   b. Update Infection control protocols and standards as needed
   c. Staff training and education on COVID-19 pandemic and infection prevention and control competencies.
   d. Implement ongoing communication plan with all employees to keep them informed of new developments.
   e. Establish recurring communication plan and resources request process with local health system partners, local public health, and local Medical Health Operational Area Coordinator (MHOAC)
   f. Identify Staff for cross training
   g. Identify Facility needs, e.g. additional hepa filters
   h. Confirm the numbers of ventilators for patient care that are available to meet the needs of available ICU licensed, surge and ED overflow space.

       i. Identify triage teams that will over-see and review the scarce resource allocation or relocation of critical care resources.

       j. Increased capacity within the hospital by creating Enhanced Airflow Rooms and equipped 4A with cardiac monitors

5. Preparation for next surge level (yellow)
   a. Prepare COVID wards and ED Surge Tent
   b. Workflows and guidelines in place to conserve PPE and Cleaning Supplies

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Scripted Trigger Criteria to move to Yellow Surge Status:
- 60% - 100% of isolation beds are occupied by patients requiring enhanced airborne isolation
- COVID-19 patients census 15-17 patients
- Five or more COVID-19 patients are on a mechanical ventilator

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Executive Summary - Status YELLOW

1. Overview
    a. Yellow status connotes a modest COVID volume state where there are consistently sufficient patients to sensibly create COVID cohorted wards
    b. Use existing equipment, staff, and supplies
2. Patients
    a. COVID patients are cared for on units based on care level needs (ie ICU level on ICU unit).
    b. COVID patients may be cohorted on units
    c. ED and inpatients are placed in negative pressure rooms or private rooms with HEPA filters
    d. Open 4A as needed for additional COVID capacity
    e. Consider ED surge tent for additional ED capacity
3. Staffing
    a. Cross train staff to provide care and services in critical care units
    b. Identify cross trained staff and identify patients to move to other units as the situation progresses
    c. Recurring communication with outside staffing resources in preparation for status orange
4. Important Activities
    a. Begin shifting work from Respiratory Therapist (RT) to floor nurses for routine treatments
    b. Postpone non-essential care to protect patients and supplies of PPE
    c. Prepare ED Triage tent
    d. Consider Hot wards (designated COVID wards)
5. Preparation for next surge level (orange)
    a. Prepare hot wards: Intermediate Care Unit (IMCU) and 4A
    b. Prepare/cross train outpatient staff for inpatient service

Scripted Trigger Criteria to move to Orange Surge Status:
- 100% - 130% of isolation beds are occupied by patients requiring enhanced airborne isolation
- All rooms on IMCU and 4A units are occupied by COVID-19 patients and we are considering expanding to 4B unit should COVID-19 care space be needed
- Five or more COVID-19 patients are on a mechanical ventilator

Executive Summary - Status ORANGE

1. Overview
   a. Orange status connotes a significant COVID-19 volume state where care is shifted to areas that don't typically handle the acuity that will be assigned in this status
   b. Impact to hospital services anticipated (ie. Will limit incoming transfers and elective procedures)
   c. Impact to Ambulatory services anticipated (ie. may pull ancillary and clinic staff to support hospital)

2. Patients
   a. Designated COVID units: IMCU, 4B (Med/Surge/Telemetry) and 4A
   b. ED and inpatients are placed in negative pressure rooms or private rooms with HEPA filters
   c. Hot wards opened to cohort patients and staff to save supplies and minimize exposure risk
   d. ED surge tent utilized regularly, and non-COVID-19 care pushed to fast track whenever possible
   e. ED triage tent opened; ED patients screened outside
   f. Consider further restriction of visitors per AFL 20-38.5 Visitor Limitation Guidelines

3. Staffing
   a. Prepare 4B to accept IMCU level COVID patients
   b. Staffing challenges predicted at this level for two reasons
      i. Shortages in staff with experience in critical care
      ii. Shortages related to staff illnesses and absences
   c. Staffing modifications will include
      i. Physicians shifting to ward-based teams
      ii. Nurses with critical care skills paired with floor nurses to care for groups of patients and allow for amplification of skills and cross training
      iii. Introduction of hierarchical structures for critical care physicians who shift towards more supervisory and training roles
   d. Scheduling could be modified to include alternative shift times/lengths based on need
   e. Apply for program flex on Nursing Documentation under emergency declaration waivers.
   f. Consider applying for program flex Staffing Waivers.

4. Important Activities
   a. Cross training of staff

    b. Tight control of PPE

    c. Restriction of non-essential care to protect patients and PPE supplies

    d. Exhaust all contracted critical supply options.

    e. RT staff will prioritize emergencies over routine care shifting some routine ventilator care to bedside nurses and physicians

    f. Communication with DOC and MHOAC regarding critical staffing or supply needs.

    g. Plan to convert two ED non-isolation rooms to Enhanced Air Flow rooms

5. Preparation for next surge level (Red)

    a. Prepare PACU to accept IMCU/ICU level COVID patients

    b. Prepare Miller Wellness Center (MWC) to be a non-COVID Emergency Department

    c. Identify facility needs and equipment for all COVID areas

    d. Staffing resource request to DOC as needed

Scripted Trigger Criteria to move to Red Surge Status:
- Greater than 130% of isolation beds are occupied by patients requiring enhanced airborne isolation
- 4B unit are fully occupied by COVID-19 patients and more COVID-19 patients and we are considering expanding to PACU unit should the COVID-19 care space be needed
- IMCU and 4A units are fully occupied by COVID-19 patients requiring mechanical ventilation and there are greater than 10 ventilated patients on IMCU unit.

Executive Summary - Status RED

1. Overview
    a. Red status connotes a severe COVID volume state where COVID cases generally outnumber non-COVID cases and demands exceed existing resources
    b. Hospital services impacted (ie. emergent procedures only, no incoming transfers)
    c. Ambulatory services impacted (ie. may close clinics and divert staff to hospital)
    d. State/federal staffing needed
    e. Alternative Care Sites needed
2. Patients
    a. COVID wards are hot wards: IMCU, 4A, 4B, and PACU
    b. Re-apportion other units for non-COVID patients
    c. ED surge tent utilized regularly
    d. Consider using MWC into ER for non-COVID care
3. Staffing
    a. Staffing challenges predicted at this level for two reasons
        i. Shortages in staff with experience in critical care
        ii. Shortages related to staff illnesses and absences
    b. Staffing modifications will include
        i. Activate established contracts to bring on additional staff
        ii. Hierarchical structure for critical care physicians supervising other physicians
        iii. Hierarchical structure for critical care nurses supervising other nurses
        iv. Hierarchical structure for other ancillary staff (e.g. respiratory therapists) to supervise other ancillary staff
    c. Schedules modified to include alternative shift times/lengths based on need
4. Important Activities
    a. Regular use of alternative care sites to move stable patients out of CCRMC
    b. Tight control of PPE
    c. Shift recovery of post-partum mothers to alternative areas like Labor and Delivery (L&D) suites, nursery 2, and any other care area needed to ensure that 5C (Post-partum Unit) can be flexed up for non-COVID medical/surgical care
    d. 1 Operating Room (OR) open, all elective procedures cancelled, all elective Gastrointestinal (GI) procedures cancelled
    e. On-going communication with DOC and MHOAC regarding critical staffing supply needs.
5. Preparation for next steps

    a. Early identification of subsequent potential care areas in case the surge continues further

<mark>6. Resource allocation in condition of absolute scarcity will be followed as proposed by CCRMC Bioethics committee. The guidelines from this group included input from patients, ethicists, doctors, nurses, social workers, and health equity advocates</mark>

    a. Formation of triage teams: The purpose of this team will be to adjudicate allocation of scarce resources on a case-by-case basis in order to decrease the moral burden imposed on frontline staff to make resource decisions at the bedside.

    b. Allocation Process under "Crisis" Standards: In order to appropriately and justly allocate scarce resources we modify the utilitarian framework of "save the most lives" with a multi-principle approach.

    c. Reassessment for ongoing provision of critical care and ventilator support: Triage team will conduct reassessments at least every 24 hours for all patients utilizing critical care resources. Periodic evaluations are necessary to ensure that as many patients as possible can benefit from the scarce resource/therapy.