

## Institution Preparedness for Next Pandemic / Future Waves

### Emergency Operations:

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- Ideally, a single centralized hospital command center should be operationalized before the crisis hits.
- Plans for discontinuing normal services, such as elective surgery, should be considered when appropriate.
- Create a daily report to all unit managers or even all staff. Create and electronic dashboard to track beds and limited resources
- Communication strategies should be engaged early so employees and patients know where to find the information they need
  - Establish all sorts of communication channels, including a patient hotline, nurse hotline, etc. Open up communication channels within the hospital and within the region and state.
  - Create an external communication system from your health care system. This should build on established relationships and include community alliances (including groups like Kiwanis and Lion's Club), religious groups, ancillary healthcare facilities like clinics and nursing homes.
  - The COVID leader should be responsible for communicating to the government agencies in your area on a regular and scheduled basis. Ensuring regular communication establishes control and structure.
  - Create a daily contact with EMS. There should be a plan/system for early notification of patients with suspected infectious disease or other special needs. If there is a community plan to congregate patients in one facility, they should be including in that planning and notification.
- Hold a daily huddle, or even huddles every shift. There should be at least four topics that get talked every meeting: changes in treatment, your workforce, your resources (supply and shortages including beds), and cost.
- Create a daily report to all unit managers or even all staff. Create and electronic dashboard to track beds and limited resources within your hospital and create a local/regional/state dashboard populated with data from reliable sources and update as often as needed/possible.
  - Three critical sources of information: internal to the hospital shared across specialty areas, external care facilities such as long-term care affected, and local/state/national health jurisdictions. Expect the latter to be less facile.
- Anticipate shortages particularly anything that components or manufacturing processes outside the US.

### Patient Volumes:

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- In a pandemic, expect volumes of lower acuity patients to drop drastically.
- The ED and hospital may become overwhelmed with sick patients, or, if the disease is not active in the area, may see only the sickest individual.
- While volume drops, acuity does not.

### Staffing:

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- Expect call off rates to be higher, both because of fear and because of quarantine.
- During the first wave of the COVID Pandemic, call off rates were highest among nurses.
- Additionally, EMS was hit hard during the COVID Pandemic with the highest number of deaths
- Standard staff per patient ratios do not apply when patients are sicker and there is increased workload to donning and doffing for each patient.
  - Institutional response should be nimble and divert staff to where they are needed.
  - Lesson learnt: During the COVID Pandemic, one of the more successful models were the large staffing companies with contracts throughout the US. Many of these already had 'travel teams' of individuals

already holding multiple state licenses and credentialed in multiple hospitals. This not only increased staffing numbers, but also quality, as these physicians carried with them expertise from prior experience.

- Specialty needs vary during pandemics and some physicians will need to pivot to new roles and quickly gain expertise. Short educational courses can allow physicians to use their skills in new ways and with new populations.
  - Lesson learned: examples from this pandemic include anesthesiologist deployed to the ED to perform intubations, emergency physicians working in the ICU, enlisting medical personnel in administrative roles and retired physicians, and using medical students creating videos on basic ventilator setup.

### Role of Senior Leadership:

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- It is important that leadership is visible.
  - In one case, senior leadership travelled with the travel teams.
- Presence of leadership on the patient units and ancillary units is important. Daily rounding on staff.
- Establish a leadership team with a single head position (CMO). The team has to be a collaboration and should include: Chief of Nursing, HR, etc. Someone that can:
  - track staffing needs and illnesses and coordinate the needs of different units.
  - tracks supplies, especially looming shortages.
  - contract costs
  - address the safety issues

### Staff Wellbeing:

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- Set up an employee counseling service, a peer support program, the battle buddy system, or Psychological First Aid.
- Be aware and sensitive to the physician, emotional and mental well-being of your staff and team. Give all staff including physicians permission to have and express feelings, such as fear, anger grief and encourage them that if they needed to, take a break, go into an empty room and have a good cry.
  - Within the hospital create small community groups that meet weekly or biweekly for an hour to just vent. It is important not to isolate to be able to share your vulnerability
  - Some signs to look out for are sadness, moodiness, and irritability. Especially anger directed at family members. A big warning sign is increase in use of substances.
  - We react to a crisis like a pandemic in a somewhat predictable manner. The stages of grief and dying described by Dr Elisabeth Kubler Ross and the phases of a disaster will likely be replaced by more sophisticated research. Be aware of these stages and anticipate the reaction from staff, patients, and family members
  - Diet and sleep are essential. Consider providing food to staff.
- Pandemics, unlike natural disasters, are marathons. It is important for staff to have regular duty hours and times of rest.
  - We need to know how to best care for patients but as importantly we need to know how to protect ourselves, our team and our families. Education on best practices around infection control, like donning and doffing, help staff be less stressed about bringing something dangerous home

### Patient Disposition:

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- Meet with post-acute facilities early to determine guidelines for accepting new and established patients who are well enough to be discharged. Set up constant communication to monitor capacity.
- Recognize that the failures of our system of care will be worse during a national emergency. Vulnerable populations will be more vulnerable and more exposed.

- Develop options to quarantine and house homeless individuals during the pandemic. Look carefully at the demographics of your patient population and anticipate the needs of vulnerable populations. Compare your population to those in areas already hit by the disease.
- Behavioral health patients and placements for boarding (inpatients in the ED) patients need a special plan because they can clog up your throughput and they not only that they risk the patients that you're boarding contracting the illnesses.