Developed 2/7/22
Authors: IC Medical Branch Director, Operations chiefs at MHC & HH

SIH Incident Command PUI Admission Plan – COVID-19 Pandemic Operating Period

Herrin Hospital PUI Plan

If/When Herrin Hospital depletes their supply of rapid covid PCR tests, the hospital will implement a PUI admission plan.

Medical Level of Care Admissions

Phase 1

Trigger: SIH is down to 50 rapid PCR tests plus 48 hours of current daily burn rate.

Estimated time needed to implement: 24 hours

1.) North will be converted to the Covid/ PUI department. If the department has post-covid and/non-covid patients, offloading to another bed in another department will occur.
   a.) All medical/surgical level of Care (LOC) Covid and PUI patients will be admitted to North in private rooms.
   b.) Consider double occupancy of confirmed positive patients on North to increase PUI bed availability when census reaches 24 patients. PUIs cannot be placed in double occupancy.
      - North will require an additional (4) RNs and (2) PCTs to support census greater than 24 patients. This would allow us to go to 34 PUI/Covid patients (Ratio 1:4 RN, 1:8 PCT, Free SS)
      - Consider limiting Inpatient Rehabilitation Facility (IRF/ARC) patients.
      - Additional beds needed to increase to semi-private beds on north of (10) beds. Rooms 101-119 would convert to semiprivate.
      - (5) workstations on wheels (WOWs) needed
      - (10) additional call lights and whiteboards for temporary bed 2 in odd rooms.
2.) Once the patients covid results are released
   a. Confirmed positive patients will remain on North.
   b. Confirmed negative patients are immediately moved to Observation, Ortho, or Medical. Covid negative patients should not remain in the department. The rooms must be available for PUI and confirmed positive patients.

** Additional EVS support will be needed to ensure rooms are turned over timely.

** Inpatient Admission Covid Swabs priority to be resulted.

Phase 2

Trigger: Herrin Hospital North Unit is at peak census of confirmed positive patients and/or PUIs and zero rapid PCR tests available.

Estimated time needed to implement: 48 hours

1.) North remains confirmed positive and the PUI department.

2.) Observation is converted into a 2nd PUI unit. Engineering to convert to negative air. Only PUIs will be placed here.
    a. Confirmed positive will be transferred to North when bed is available.
    b. Confirmed negative patients are moved to Ortho or Medical as soon as possible.
        i. Rooms need to be available for future PUI admissions.

3.) Consider limiting IRF patients to anticipate needing additional medical beds.

** Observation can be converted to negative air. Rooms become hot quickly and no bathrooms in rooms. This would be a temporary staging location until PCR resulted.

PCU Level of Care Admissions

Phase 1

1.) PCU PUI patients admitted to PCU in a private room.
    a.) Once results are released: If patient is positive, patient is placed in double occupancy room with another confirmed positive patient where appropriate.
    b.) If patient is negative, patient is placed in double occupancy room with a confirmed negative PCU patient where appropriate.

Phase 2

PCU at peak census (9) of confirmed positive, PUI, and confirmed negative patients ***or*** PCU has several no open rooms due to the amount of PUIs in the department without PCR test results.

1.) Consider internal load balancing
2.) Consider holding – Dependent on time of day and state of the ED or PACU/SDS
3.) If ICU bed is available, consider admitting as PUI overflow. Once results are released move to appropriate bed on PCU.
4.) Consider placing PUI PCU level of care patients on Observation if a covid PCU bed and/or regular PCU is available when results are released.
    a. Require 1 PCU nurse for every 3 PCU PUI on observation. 1:3 Ratio
    b. Must have trained staff to care for PCU patient in observation.

ICU Level of Care Admissions

1.) All ICU level of care admissions will be admitted to ICU. All rooms are private and negative airflow.
2.) If ICU is full
    a.) Consider holding - Dependent on time of day, state of the ED or PACU/SDS, and condition of the patient.
    b.) Consider transferring to MHC
    c.) Consider transferring out of SIH
    d.) Surge into PCU if PUI bed is available and additional ICU nurse is available.

Developed 2/7/22
Authors: IC Medical Branch Director, Operations chiefs at MHC & HH

MHC Covid PUI Plan

Possible negative beds

Department	Negative Beds	Total Beds
4 Medical	25	25
4 Surgical	15	35
PCU	1	28
SDICU	7	21
ICU	9	21
Total:	57	130

Other negative airflow options: Same day surgery

Phase 1

Trigger: SIH is down to 50 rapid PCR tests plus 48 hours of current daily burn rate.

Estimated time to implement: 24 hours

- Offload non-Covid, non-PUI patients from 4 Medical and surgical negative beds
    - Assess which patients can be cared for in Peds as an overflow
    - Transfer to non-negative air beds as appropriate and able
- Double up all confirmed covid positive patients in semi-private rooms on 4 Medical as able.
    - Confirmed positive test must be done for the current admission.
- Admit PUI into negative private bed in department of appropriate acuity.
- Once test results confirmed, patient remains or is transferred to most appropriate bed for needed care.

<u>Considerations</u>

- Preserves nursing resources and keeps nurses in home units
- Will require increased resources from EVS due to increased room turn over.
- Lab will need to prioritize admission testing

Phase 2

Trigger: When phase 1 is complete and beds are at 95% capacity.

- Add scrubbers in appropriate rooms to expand negative capacity as needed. This would increase our negative capacity by a minimum of 7 additional beds.
- Begin preparation for phase 3.

Phase 3

- Assess need to open PUI unit similar to early in pandemic
- Only option for this due to negative airflow limitations would be Same Day Surgery

<u>Considerations</u>

- Surgery schedules would need to be minimal and would need to relocate SDS
    - Need to relocate call teams currently using SDS bays

- Places strain on nursing resources.
- Requires additional EVS resources due to every patient being transferred after test results.