RIGHT TO CARE

COVID-19 DATA ANALYSIS AND ADVICE GROUP

# TECHNICAL ADVICE DOCUMENT

# DISASTER MEDICINE:

# HOSPITAL PREPARATION ACTION PLAN 3

(THESE ACTION PLANS WILL BE RELEASED AS SEQUENTIAL NUMBERED ACTION PLANS TO BE USED BY HOSPITAL TO PREPARE FOR THE COVID-19)

The Actions Plans are presented as a free service to hospitals by the panel and by Right to Care


THEO LIGTHELM

DISASTER MEDICINE CONSULTANT: RIGHT TO CARE



| DISASTER MEDICINE CONSULTANCY PANEL | | |
|---|---|---|
| Col (ret) Theo Ligthelm | Disaster Medicine Consultant | theo@crisismedicine.co.za |
| Dr Wayne Smith | Director Disaster Medicine WC | Wayne.Smith@westerncape.gov.za |
| Col (ret) Willie Nieuwoudt | Disaster Medicine Consultant | nieuwoudt.w.t@gmail.com |
| Me Mande Toubkin | Disaster Medicine Expert Netcare | mande.toubkin@netcare.co.za |
| Col Franco Chamberlain | Disaster Medicine Consultant | francochamberlain@gmail.com |
| Dr Vernon Wessels | Disaster Medicine Expert: ER-24 | Vernon.Wessels@er24.co.za |
| Me René Grobler | Disaster Medicine Expert Netcare | Rene.Grobler@netcare.co.za |
| Dr Charl van Loggerenberg | Disaster Medicine Expert Life Health | charlvl@life.co.za |



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## 1.1 LIST OF FIGURES



# 2 ACTION PLAN 3

Based on the Disaster Medicine literature and personal experience the following action plan is recommended for hospitals AT THIS STAGE by the Consultancy Panel while preparing for the Pandemic.

This technical advice document must be read in conjunction with the Plan to Manage COVID-19: Spatial Response Strategy for the Epidemic (Republic of South Africa, 2020).

**DISASTER MEDICINE ALGORITHM**[1]

C: Command and Control

The various steps of this Algorithm will be addressed in the follow-up Action Plans.

## 2.1 COMMAND AND CONTROL

The cornerstone of successful medical management of a disaster or major incident is effective and clear command and control.

It is recommended that each hospital **establish a clear centralised command and control system** in the management of this Pandemic. It is highlighted that the emphasis be placed on command in a situation of this nature, and not on management. Command is a function vested in an individual, whereby that individual will plan, organise, lead and control the hospital activities, through and with others (Wallis & Smith, 2011).

[1] (Advanced Life Support Group, 2019)

### 2.1.1 LEVELS OF COMMAND DURING THE PANDEMIC

Within a Pandemic (or other disaster situation) three clear levels of command can be distinguished where-in the hospital will function. (**different terminology** may be used within the various provinces and hospital groups but the principles stay unchanged) (Wallis & Smith, 2011) (Toubkin, 2020) (Advanced Life Support Group, 2019).

| | | |
|---|---|---|
| **Gold Command** | **Strategic Level** | • **National Joint Operations Centre (NatJOC)**<br>• **National Dept of Health Incident Management Team and Ministerial Advisory Committee**<br>• **Private Hospital Groups Joint Operational Centres (JOC)** |
| **Silver Command** | **Operational Level** | • **Provincial "War Rooms" / Emergency Operation Centre (EOC)**<br>• **District Head Offices of Public Sector (where applicable)**<br>• **Regional Head Offices of Hospital Groups (Where applicable). In certain Private Hospital Groups this level has not been activated and individual hospitals reports directly to a central JOC at Head Office.)** |
| **Bronze Command** | **Tactical Level** | • **Hospitals**<br>• **Other health structures** |

Within the Management of the Pandemic (or other disaster situation) the hospital can structure internally in the same fashion to structure clear levels of command

### 2.1.2 ESTABLISHING A HOSPITAL COMMAND CENTRE FOR THE PANDEMIC

It is recommended that a central Command Centre is established within each hospital from where all actions within the hospital is coordinated. All instructions to the hospital channels through the Command Centre and all feedback and requests to higher level (Silver Command) flows through the Command Centre.

This facility can be established in any suitable space within the hospital, the most suitable facility is normally the Board Room of the hospital. It is essential that the facility has adequate communication facilities for the command to communicate within the hospital, with external support structures and with the higher-level structures (Silver Command) (Wallis & Smith, 2011).

This command centre needs to monitor the functionality of the entire hospital and therefore requires statistical feedback on a continuous basis that is recorded in a visible method such as whiteboards or electronic screens.

### 2.1.3 MEMBERS OF THE HOSPITAL COMMAND

The command structure should include all the top management of the hospital, enabling immediate decision making. Members should include as the minimum (Advanced Life Support Group, 2019) (Wallis & Smith, 2011):

- The Chief Executive Officer (CEO) or Hospital Manager as the COMMANDER
- Clinical Manager or Chief Medical Officer of the hospital as the medical commander
- Nursing Service Manager of the hospital as the nursing commander
- Support Services Manager coordinating all the support services as the support sub-commander
- Financial Manager if required
- Communications Expert if available

Access to the Command Centre is controlled and only authorised/accredited persons should be allowed (Powers & Daily, 2010). In view of the current COVID-19 situation, all Command members to sign daily register (similar as screening tool at hospital entrances) and do daily temperature checks on arrival.

In specific hospitals the composition of the team may differ, but the functions should be addressed. Including too many role-players in the Command Centre is strongly warned and advised against, as it results in a paralysis in decision making and an unmanageable process.

The group needs to be supported by secretarial and essential administrative staff and a record of all decisions should be kept. Supporting staff should be kept to a minimum but be able to assist the specific commander with administrative tasks to prevent the commander from becoming involved in data capturing. The Commander's focus should be to Command!

**It is recommended that the hospital, at this present stage of the pandemic;**

- **Establish their Command Centre**
- **Identify the staff members who form part of it**
- **Identify at least two secundi for each command-role that could stand-in for them if not available**
- **Identify the supporting secretarial and administrative staff for the Command Centre.**
- **All members in the Command Centre to sign Non-Disclosure Agreements (if not done so already) as they will have access to very sensitive and high-level patient information.**

### 2.1.4 FUNCTIONING OF THE COMMAND CENTRE

It is recommended that hospitals establish their Command Centre at this time and then scale-up its functioning as the situation develops. Meeting once daily may be adequate at this stage, scaling it up to a 24-hour operation should the need arise.

This will require a relief team, for example of the night matron/ night manager taking command at night and the rest of the team on stand-by.

### 2.1.5 COMMUNICATION CAPABILITIES

The Command Centre must be able to communicate within the hospital, with outside support structures and with higher-level structures such as Silver Command.

This requires adequate telephones for the command-staff. Boardrooms seldom have more than one telephone line available. A practical short-term solution is to have duplicate plugs installed on the office telephone lines of the management members, to allow them to unplug their office telephone and plug it into the duplicate plug in the board room and continue functioning (Wallis & Smith, 2011).

An ability to receive electronic communication i.e. e-mails and to join electronic meetings through electronic capabilities such as zoom meetings or skype meetings is essential.

This may be backed-up with radio or other forms of additional communication.

Social media platforms, e.g. WhatsApp and Telegram can be very useful in keeping a record of communication and can be downloaded to be used as a record of communication.

**It is recommended at this stage of preparation for the Pandemic that hospitals test their communication capabilities in their Command Centres and that internal alternative communication methods also be tested.**

### 2.1.6 STATISTICAL INFORMATION

The Command Centre should maintain a detailed statistical overview of the hospital functioning on a continuous basis and provide a consolidated report on a structured timeline to Silver Command. This aspect will be addressed in the next action plan with detailed information of bed-statistics.

Other statistical requirements from Silver Command must also be identified and confirmed to prevent misunderstandings or duplication of efforts once the requirement for statistics increases during the Reception Phase.

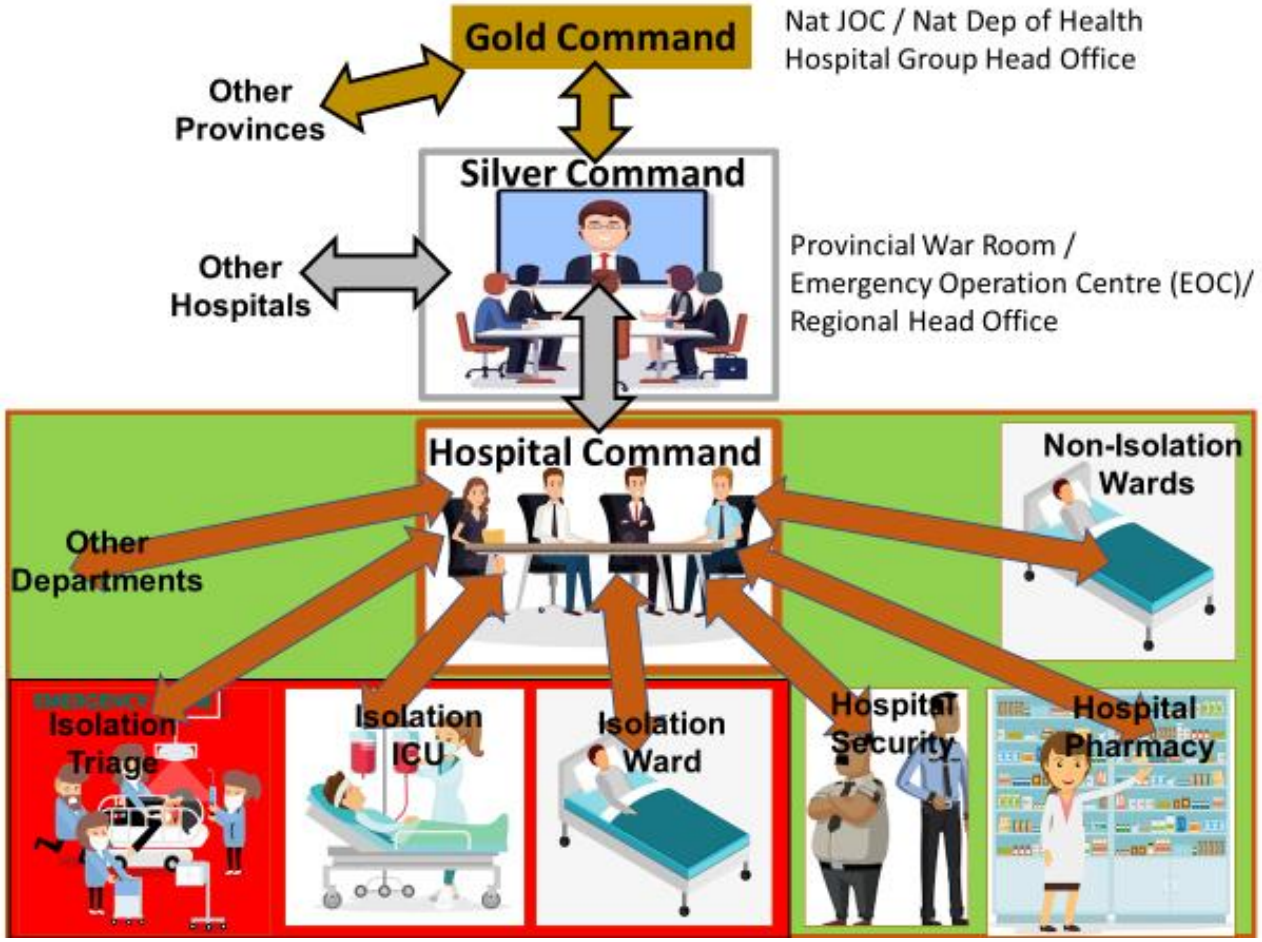


**Figure 1: Schematic Outlay Hospital Command**

This action plan will be followed by a sequentially numbered Action Plan continuing the preparation

## 3 REFERENCES

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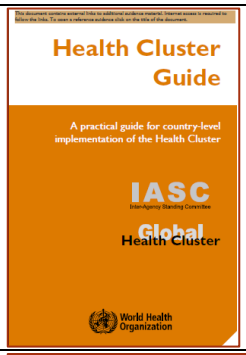
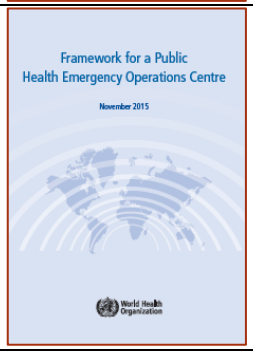
## 4 LINKS

The following links are available for use:

| | | |
|---|---|---|
| **World Health Organisation: Health Cluster Guide** |  | https://www.who.int/health-cluster/resources/publications/hc-guide/en/ |
| **World Health Organisation: Handbook for the Developing a Public Health Emergency Operational Centre** |  | https://apps.who.int/iris/handle/10665/277191 |
| **World Health Organisation: Health Emergency Operations Centre** |  | https://www.who.int/ihr/publications/9789241565134_eng/en/ |

# COVID-19 HOSPITAL PREPARATION CHECK-LIST FOR PREPARATION THIS FAR

| Ser No | Action | Date Completed |
|---|---|---|
| 1. | Training completed in triage Sieve and Sort and posters are printed and available for use. | |
| 2. | Triage tags are available and supports the Triage process | |
| 3. | Posters for doffing and donning PPE from the NDOH Guidelines are printed and available | |
| 4. | Screening, testing and triage facility was planned, and equipment is available | |
| 5. | Surge capacity of the facility is calculated **and recorded** indicating:<br>• Additional space for ICU/ventilation capabilities<br>• Additional patient care space for high dependency care<br>• Additional patient care space for low dependency care | |
| 6. | Bed repairs / additional sources to provide beds to surge capacity in in place | |
| 7. | All available ventilators were identified and process to service the unserviceable ventilators is in place | |
| 8. | Oxygen cylinders and regulators are checked and serviced | |
| 9. | Supply line for oxygen cylinders refills were reviewed and checked, supplier can shorten turn-around time if required | |
| 10. | The Red Area that will be used for patient care was identified and include all the levels of care available at the hospital | |
| 11. | The Red Area is separated from the rest of the hospital by a Yellow Transit Area. The Yellow Area has adequate facilities to decontaminate staff and equipment coming out of Red Area. | |
| 12. | Plan is in place to move COVID-19 patients from Red Area to and from x-ray department | |
| 13. | The Green Support Area has been identified | |
| 14. | All areas are demarcated, and signage is available to be placed when required. | |
| 15. | The PPE guidelines from the National Department of Health was evaluated and all needs determined. | |
| 16. | PPE stock is ready and sufficient for at least seven (7) days | |
| 17. | Temporary ventilation capability is planned for movement of patients if required and oxygen is available for transfers. | |
| 18. | Planned beds can accommodate Fowlers position and oxygen administration. | |
| 19. | Palliative Care is considered, facilities and staff were planned | |