

Alternative Care Site Planning in Interior Health

During an influenza pandemic, traditional health care facilities, including hospitals and community health centres, are likely to experience a surge in patients with influenza-like illness who will seek assessment, care, support, and information. Considering the over-capacity levels at which many of these facilities currently operate, the ability of health care professionals to provide “normal” levels of service during a pandemic is extremely unlikely. This situation requires health managers to consider the establishment of alternative care sites (ACS) for certain services that would otherwise be provided in an inpatient facility or hospital emergency department.

When considering the creation of an ACS system for Interior Health (IH), several key issues were raised and examined by the Infectious Hazards Emergency Response Planning Task Force (TF), including:

- The level and scope of care to be provided;
- The physical space required to establish an ACS;
- The human resources considerations for delivering a reduced level of care in such facilities;
- Medical equipment and facility requirements; and,
- The integration of an ACS within the overall delivery of health care during a pandemic.

After feedback and discussion from the TF, three models of alternative care sites were recommended that could be considered by local health care planners to alleviate the patient surge that is anticipated for traditional care facilities. These models are organized by three ascending tiers to highlight two principles: how an overall ACS patient streaming system could link one subsequent site to the next and what factors must be taken into consideration with regards to the demand on physical and human resources for each ACS. The recommended ACS models include:

- Tier 1: Primary triage and rapid patient screening;
- Tier 2: Limited supportive care for non-critical influenza patients; and
- Tier 3: Expanded ambulatory care.

Primary triage and screening will allow health care personnel to quickly separate those patients requiring critical care from those needing self-care information and pandemic influenza education, while limited supportive care of non-critical patients with influenza is intended for those patients that do not require a hospital bed but would benefit from some basic care services (i.e., antibiotics, hydration, and pain management). Expanded ambulatory care will address those non-critical patients that require further monitoring, on-going hydration, and oxygen, as well as assist with outpatient management to create space for incoming inpatients.

Disclaimer

This chapter is intended as guidance only. It is meant to inform and support local area emergency planners and health care managers in the consideration of alternative care sites when planning for the next pandemic. Ultimately, the decision to deploy, or not deploy, any of the recommended ACS models will depend on the unique characteristics and needs of each community and its individual care facilities during a pandemic. Should any of the following ACS models be utilized during a pandemic or preparedness exercise, the following chapter should provide overall guidelines for their creation and operation.

Planning Assumptions – Alternative Care Sites

The following planning assumptions are provided to outline the context and rationale behind the ACS strategy for Interior Health:

- The ACS model presented in this chapter is based on current best practices and research on other ACS systems from across Canada and the United States.
- The number of infected people requiring outpatient medical care and hospitalization will overwhelm the local health care system.
- During a pandemic, hospital resources will be redirected to provide for the most seriously ill.
- The increased health care demands associated with pandemic influenza cannot be managed by health care facilities alone. An effective pandemic response must include cooperative strategies that use a variety of health care entities including hospitals, clinics, long-term care facilities, private practice physicians, and home health care providers.
- To maximize health care resources and achieve the optimal benefit for the most people, traditional standards of care may need to be altered. “Sufficiency of Care,” which is medical care that may not be of the same quality as that delivered under non-emergency conditions, but that is sufficient for the situation, may be the standard of care during influenza pandemic.
- Alternative care sites are designed as “resources of last resort,” when expansion and augmentation of existing medical resources are severely challenged or exceeded. It is recognized that the majority of health care providers are most effective when providing medical care within or very near to usual medical settings.
- It is understood that ACS, as an extension of existing medical resources, are more feasible than establishing independent alternative care sites that must be separately mobilized (both services and management/administration), sustained, deployed, integrated, demobilized, and rehabilitated.
- Selecting and staffing of the alternate care site should be done in conjunction with the local health care providers and hospitals, but it should not be assumed that the local providers will be able to completely staff the site. Some community members will have to be trained to assist at each site in various capacities.
- Hospitals and other health care entities will likely experience staffing shortages throughout the Pandemic Period and into the subsequent recovery period. Under specific emergency conditions, volunteers, retired health care professionals and trained unlicensed personnel may be used to provide patient care in a variety of health care settings.
- The pandemic may occur in two or more phases and alternative care sites may open, close, and re-open depending on the community needs.

- Currently, there are no operational provincial guidelines for the creation or maintenance of alternative care sites for surge management during a pandemic.
- Given the geographic make-up and distribution of Interior Health communities, the recommendations contained in this chapter are meant to guide frontline health care planners in their surge management planning for a pandemic.
- The ACS recommendations are based on discussions at the TF level that included a feasibility review of various alternative care site models and considered the unique characteristics of Interior Health urban and rural populations.
- The three modals presented below are meant for health care leaders in small, medium, and large populations to manage the anticipated patient surge during a pandemic. It is understood that frontline planners may adopt and/or revise the following recommendations to facilitate the development of the most effective ACS system for their communities.

Review of Interior Health Facilities

In order to understand how and where ACS facilities may be activated in IH, it is important to first understand the current structure and overall capability of Interior Health facilities. Hospital and medical care sites in Interior Health are broken down into two categories: Health Centres and Hospitals. Health Centres are further divided into Community Health Centres and Primary Health Care Centres. Hospitals are then broken down into Community Hospitals and Regional Hospitals (including tertiary referral hospitals).

A breakdown of the current health centres and hospitals by health service area is provided in **Appendix 1**. A breakdown of the hospital and health centre bed inventory (current as of May 2008) also by health service area is provided in **Appendix 2**.

Health Centres

Community Health Centres offer a variety of services in one location. The types of services delivered depend on patient needs and on whether comparable services are available nearby. Centres that offer one type of specialized outpatient care procedure (e.g., eye surgery) are classified based on that service. Community Health Centres do not have acute care beds, but may offer:

- Basic laboratory and radiology (x-ray) services
- Urgent care
- Outpatient ambulatory care procedures such as day surgery
- Community services such as public health or physiotherapy
- Long-term residential care services
- On-site doctors' offices

Primary Health Care Centres are currently available in eight Interior Health communities. They are Community Health Centres with a more comprehensive and coordinated approach to health care delivery. Each Primary Health Care Centre has an interdisciplinary health care team that provides a range of services in a single site – i.e., a checkup with a family doctor, a visit to a physiotherapist, pharmacist, or public health nurse. The selection of services offered in each Primary Health Care Centre reflects the unique needs of its community.

Hospitals

There are 16 Community Hospitals operating in Interior Health. There are two levels of Community Hospitals – Level 1 and Level 2.

"Level 1" Community Hospitals may provide:

- Laboratory and radiology (x-ray) services
- Emergency services that may be available 24 hours per day, depending on the facility
- Acute care beds for patient admissions for general medicine, observation, assessment, convalescence and palliative care
- Low-risk obstetrical care in rural or remote areas
- Outpatient ambulatory care procedures

"Level 2" Community Hospitals provide the same services as "Level 1" Community Hospitals, such as laboratory and radiology (x-ray) services and acute care beds. However, they also offer:

- 24-hour emergency services with registered nurse (RN) triage
- Obstetrical care
- Some core physician specialties such as internal medicine and low complexity general surgery including ambulatory care day surgery

Interior Health's system of Regional Hospitals provide specialized care in Cranbrook, Trail, Vernon, Penticton, Kelowna and Kamloops. Each Regional Hospital is responsible for providing core medical and surgical specialty services to patients throughout its service area. Service Area Hospitals in Cranbrook, Trail, Vernon and Penticton provide acute care beds, obstetrical care and all the other services one might expect at a Community Hospital. They also offer:

- Laboratory (Lab Level 3) and radiology/diagnostic imaging services.
- 24-hour emergency services, ideally with in-house physicians. Emergency services at a service area hospital provide a higher level of trauma care than a community hospital.
- Core physician specialties such as internal medicine, general surgery, orthopedics, anesthesia, obstetrics, gynecology, pediatrics, psychiatry, radiology, pathology and emergency medicine.
- Some sub-specialized, physician services for medical and surgical programs.

The Regional Hospitals in Kelowna and Kamloops offer the same services as the four Service Area Hospitals, but with added levels of care. These facilities, known as Tertiary Referral Hospitals, also provide:

- 24-hour emergency services that may include trauma services
- Advanced diagnostics such as magnetic resonance imaging (MRI), nuclear medicine and cardiac catheterization
- Higher levels/sub-specialties of almost all medical and surgical services
- Tertiary services for patients with multi-system failure and those requiring vascular surgery, thoracic surgery or neurosurgery

Review of Alternative Care Facilities for Potential Use in Interior Health

During a pandemic, hospitals and community health centres are likely to experience a surge in patients with influenza-like illness seeking assessment, care, support, and information. To plan for the likely influx of patients, Interior Health has identified three models of alternative care that may be considered to alleviate the duress that could be placed on traditional care facilities. The following section is intended as guidance for health care and emergency planners to determine, first and foremost, if an alternative care site is appropriate for their facility or community and, if so, what estimated minimum baseline considerations should be addressed in order to properly implement any or one of the ACS models.

Estimated Community Impacts

To understand why a particular community or health care facility may require the creation of an ACS, it is necessary to understand what the impacts of an influenza pandemic may look like on a community level. The following chart is meant to demonstrate the estimated community impacts by sample populations. Its calculations and percentages are based on IH pandemic planning assumptions and estimates calculated by FluSurge®, the US Centers for Disease Control and Prevention pandemic modeling tool. These estimates should help planners determine what a severe pandemic (35% attack rate) could look like in their communities.

Sample size of community or local health area	Approximate # of individuals likely to fall ill (35% of population)*	Approximate # of individuals likely requiring assessment (17.5% of population)*	Approximate # of individuals likely requiring site based-care (4.5% of assessments)*	Approximate # of total deaths (0.6% of population)*
Pop. 5,000	1,750	875	39	30
Pop. 10,000	3,500	1,750	78	60
Pop. 15,000	5,250	2,625	118	90
Pop. 30,000	10,500	5,250	236	180
Pop. 80,000	28,000	14,000	630	480
Pop. 100,000+	35,000	17,500	788	600

Since it is not known when a pandemic may occur, it is important for emergency and health care planners to understand the impact that population growth may have on the potential for an ACS during a pandemic. Therefore, a chart on the current and projected Interior Health population for the year 2020 for each local health area can be found in **Appendix 3** to provide guidance with regards to forward-planning.

Considerations for the Establishment of Alternative Care Sites

Ultimately, the decision to active any or none of the recommended alternative care sites will depend on a number of factors that must account for the unique characteristics and needs of each community, and its individual care facilities. The issues for consideration will include, but are not limited to:

- The size of the community or facility in question
- The number and skill sets of available staff
- The availability of physical resources and space
- The number and types of patients presenting influenza-like illness
- The number of current patients already in the facility
- The number of incoming patients with conditions other than suspected influenza

With these considerations in mind, certain communities and health care facilities may only be able to operate one type of alternative care site, while others may be able to operate all types. Still others may realize that they cannot operate any of the suggested models.

In recognition of the varying sizes of communities in Interior Health, the remote or rural demographics that define many of these areas, and the limited human and physical health care resources that exist throughout the health authority, the three recommended ACS models have been divided into ascending tiers, 1 through 3. These tiers demonstrate the potential for an overall ACS patient streaming system that could link one subsequent site to the next and varying factors for consideration in their creation, operation, and maintenance from one subsequent tier to the next.

A system flow chart, which outlines the recommended patient flow and use of an ACS patient streaming system in Interior Health during a pandemic, can be found under **Appendix 4**. Each numbered ACS model in the chart is equated with the following descriptions found in this chapter.

Tier 1 - Primary Triage and Rapid Patient Screening:

This tier of ACS represents the potential front-end of an ACS patient streaming system. This model could also stand alone in smaller communities or facilities as a way of disseminating pandemic influenza education and self-care guidelines. As an alternative care site in a front-line capacity, the demand on human and physical resources, relative to the other ACS models, may be more pronounced depending on the number of patients or worried well seeking care and information. This ACS model will have some, or all, of the following characteristics and procedures:

- Ideally located near, but physically separate from, a hospital emergency department or health centre to minimize exposure of hospitalized patients to influenza.

- Patients with influenza-like illness are to be directed to these triage and screening areas for initial assessment.
- Critically ill patients would then be transferred to hospitals for care.
- Other influenza patients would be discharged home or provided some basic care in an adjacent or nearby limited supportive ACS for non-critical patients (if available), depending on the established pandemic response protocol.

The minimum health care staffing considerations for this type of ACS over a typical work-shift period (12 hours) are estimated to be:

Position	Skill Set Required	Quantity
Greeter	Basic	2
Unit Clerk	Basic	2
Triage Nurse	Advanced	2
Physician	Decision/Disposition	1
Security	Support	1
Housekeeping	Support	1
Porter	Support	1
Resource/Administration	Support	1
Transporter	Support	1

Tier 2 - Limited Supportive Care for Non-Critical Patients:

The purpose of this ACS model is to assist non-critical patients with pandemic influenza that do not require a hospital bed but would benefit from the provision of some basic care services. It is highly probable that this type of ACS would work in tandem with a primary triage and rapid patient screening site to provide short-term patient observation (4-6 hours), hydration, antibiotics*, and pain management. The demand on human and physical resources may be lessened if this site were attached to a primary triage and rapid patient screening ACS or other health care facility where resources could be shared. However, non-hospital site would likely increase the need for additional medical professional and support resources. This ACS model will have some, or all, of the following characteristics and procedures:

- The ACS could involve a specific, non-hospital site to provide non-critical, supportive care during a pandemic or work in tandem with another ACS or health care facility.
- Patients would be moved accordingly after an initial triage and screening at a hospital emergency department or other primary triage and rapid patient screening area, including an alternative care site.
- Patients with worsening medical conditions over the observation period would be moved to a hospital.
- Patients with less severe conditions would be cared for and treated in three areas (antibiotics*, hydration, and pain management) at the alternative care site.

* The administration of antibiotics through IV therapy may or may not be an alternative care site function pending further guidance from the provincial and/or federal governments on the expectations/recommendations for the usage of antibiotics during a pandemic.

The minimum health care staffing considerations for this type of ACS over a typical work-shift period (12-hours) are estimated to be:

Position	Skill Set Required	Quantity
RNs	Decision/Disposition	1
LPNs	Advanced	2
Basic Care Provider	Basic	3
Unit Clerk	Basic	1
Physician	Decision/Disposition	1
Security	Support	1
Housekeeping	Support	1
Food Service	Support	1

Tier 3 - Expanded Ambulatory Care:

The purpose of this ACS model could be two-fold: to receive non-critical patients from a limited supportive care ACS for further observation, on-going IV therapy, oxygen treatment (if necessary), and monitoring for co-morbidities, and receive less seriously ill outpatients from acute care beds or wards to make room for incoming inpatients. This ACS tier would be the final component of an ACS patient streaming system that includes the primary triage and limited supportive care. This ACS would represent a more significant demand on support services (i.e., food, housekeeping, etc.) than clinical resources relative to the other ACS models as patients would likely already be within a health care facility and patient to care provider ratios would be larger. Therefore, this ACS may only be appropriate for larger communities with advanced health care facilities and larger numbers of support resources. This ACS model will have some, or all, of the following characteristics and procedures:

- Designed to relieve pressure on hospitals and permit them to concentrate on sicker patients.
- Built on the premise that a system of effective outpatient management may reduce the demand for inpatient care.
- Patients requiring further observation and basic care from a limited support care ACS could also be received.
- Requests for assistance from less seriously ill patients and those given early discharge would be directed to an expanded ambulatory care facility.
- The site could be used to facilitate the rapid distribution of necessary medications and vaccines, assist in care and monitoring, and/or provide hydration and intravenous antibiotics.
- If possible, these “short-stay” outpatient areas would be within the hospital. Use of nearby unlicensed areas outside the main hospital building could also be considered.

Assuming a 50-bed unit for expanded ambulatory care, the minimum health care staffing considerations for this type of ACS over a typical work-shift period (12-hours) are estimated to be:

Position	Type of Care Provider	Quantity
Physician	Decision/Disposition	1
RNs or RNs/LPNs	Advanced – Decision/Disposition	6
Unit Clerk	Basic	2
Respiratory Therapist	Advanced	1
Case Manager	Basic	1
Social Worker	Basic	1
Medical Assistant	Basic	1
Housekeeping Staff	Support	2
Food Service	Support	2
Spiritual Services	Support	1
Security	Support	2
Patient Transporters	Support	2

Alternative Care Site Considerations Summary Chart

The following chart is a visual summary of the estimated minimum baseline considerations for the effective creation, operation and maintenance of each tier of ACS. It is meant to provide a more holistic view of the purpose of an ACS, what type of patients may be present at such sites (as well as their possible level of acuity), where these sites may be located, and the basic health care processes that would likely be performed.

	Human resources estimates	Physical resource/space considerations	Location examples	Types of patients	Likely level of acuity	Health care processes likely involved
Tier 1 – Primary Triage and Rapid Patient Screening	9 or more staff potentially required	Can be found in Section 0804 of the IH PIPP	Community health centre, regional hospitals, churches, community centres	Worried well, patients seeking information, varying levels of acuity and possible secondary complications	Low – high	Triage, self-care instructions, influenza education
Tier 2 – Limited Supportive Care for Non-Critical Patients	11 or more staff potentially required	Can be found in Section 0804 of the IH PIPP	Regional or tertiary hospitals, churches, community centres	Unstable, non-critical patients, no secondary infections or complications present	Low – medium	Pain management, antibiotics*, IV therapy
Tier 3 – Expanded Ambulatory Care	22 or more staff potentially required	Can be found in Section 0804 of the IH PIPP	Regional or tertiary hospitals	Outpatients from higher level of acuity, stable or no longer critical, no present secondary infections	Medium	Care and monitoring, medication and vaccine delivery, hydration, IV therapy, oxygen therapy (puffer treatment)

* The administration of antibiotics through IV therapy may or may not be an alternative care site function pending further guidance from the provincial and/or federal governments on the expectations/recommendations for the usage of antibiotics during a pandemic.

Screening and Diagnostic Tools for the ACS System

A number of tools have been developed for frontline IH staff to use during a pandemic when it comes to the screening/assessment, triage, and care of suspected influenza cases. These tools include:

- Disposition algorithms for adults and pediatrics
- Frontline screening assessment tools for adults and pediatrics
- Primary Assessment Records and Orders for adults and pediatrics (for use in ACS)
- Secondary Assessment Forms for adults and pediatrics (for use in acute care settings)

These tools can be found in Section 800 of the IH PIPP – Health Services Guidelines.

Infection Control Guidelines for the ACS System

In preparation for a pandemic, Interior Health has developed comprehensive infection control guidelines that are to be activated in the health authority once cases are confirmed in British Columbia. These recommended practices are meant to assist health care workers, practitioners, and the general public in understanding the measures necessary and the equipment/supplies required to limit the spread of the pandemic influenza virus once it is in circulation in the community. In addition, the practices outlined in the IH PIPP pertain to both traditional health care facilities and alternative care sites where pandemic influenza patients will likely be assessed, treated, and/or observed.

The guidelines outlined in this section of the PIPP include:

- Key terms and acronyms
- Background information on influenza transmission
- WorkSafeBC regulatory information on exposure control in the workplace
- Infection control practices in IH during a pandemic
- PPE standards during a pandemic
- Environmental infection control guidelines
- Setting-specific guidelines

These guidelines can be found in Section 802 of the IH PIPP – Pandemic Influenza Infection Control Guidelines for Health Care and Community Settings.

Interior Health's Pandemic Influenza Strategic Inventory

In preparation for the next pandemic, IH recognized a need to develop a surge capacity of strategic supplies that could be distributed across the health authority to support alternative care sites, acute care facilities, and the staff managing these health care centres. These supplies have been vetted by a number of clinical care and logistics experts within IH and will be purchased over future fiscal years.

This strategic inventory, once completed, will include supplies to address the following areas of a pandemic response:

- Basic medical treatment
- Infection control (e.g., PPE for health care staff and clients)
- Mass vaccination

The formal logistics and distribution strategy for the mobilization of this strategic inventory is currently under development. A review of the strategic inventory's supplies and quantities, along with the planning assumptions used to determine quantities for IH, **can be found in Section 0804 of the IH PIPP.**

Human Resources Considerations

During an influenza pandemic, optimum staffing levels will need to be altered to manage increased numbers of ill patients, with reduced numbers of staff. These guidelines have been designed to assist in frontline decision-making to provide optimum patient care with the resources available.

Patient/Client/Resident Care Needs and Staff Available

- I. Anticipate severe increase in patient load:**
 - Same/similar symptom set, different levels of respiratory illness
 - Influenza to compound co-morbidities (e.g. diabetes, CHF, etc.)

- II. Anticipate up to 40% decrease in staff numbers:**
 - Anticipate staff illness from influenza
 - Health care staff are often primary care providers for their own family members
 - Consider fear of contracting influenza

- III. Anticipate decreases in non-essential services and staffing:**
 - Non-essential services will decrease per operational business plan with declaration of pandemic
 - Essential services staffing levels can act as a baseline for determining patient to provider care ratios; however, there will have to be a higher patient-to-care provider ratio
 - *Note that care providers deemed “non-essential” during normal reduced activities situations (i.e., PCCs/RCCs/CRNs during job action) will be “essential” during increased care activity situations such as a pandemic to coordinate and support care, along with providing education and clinical expertise.*
 - *Consider flexible assignments and surge planning for increased staffing*
 - Healthy staff in non-essential services areas will need to be deployed elsewhere to provide care for increased patient numbers

- IV. Anticipate changes to roles or functions to meet patient care needs:**
 - Health care providers will be needed to provide and/or direct clinical care
 - Non-clinical activities will likely be provided by non-health care personnel (e.g., answering phones, photocopying, etc.)
 - Essential services to be provided by appropriate personnel familiar with care environment wherever possible (i.e., use skill sets to best advantage)
 - Non-health care providers also needed to assist with care/other indirect care activities (i.e., runner, porter, assisting other professionals)
 - Clinical skills/roles adaptation: Basic, Advanced and Decision/Disposition Care provider categories to simplify meeting patient pandemic care needs
 - *Interventions may be required beyond usual scope in extraordinary circumstances; patient safety/risk to determine individual health care professionals’ competency to perform activities, while additional education will likely be required for delegated functions*

Care Provider Skill Sets and Support Services

The following table is provided for frontline planners as they consider the types of human resources and skill sets required to operate alternative care sites within their communities. Based on the human resources section of the Ontario Health Plan for an Influenza Pandemic (2007), the skill sets are divided into four categories:

- Basic Care Provider
- Advanced Care Provider
- Decision/Disposition Care Provider
- Support Services

The type of ACS to be activated will likely affect the types of human resources required to staff and manage the delivery of alternative care. Planners are encouraged to link directly with their own on-site management team to consider the necessary HR requirements and their distribution across multiple ACS (if necessary).

	Basic Care Provider	Advanced Care Provider	Decision/Disposition Care Provider	Support Services
Background	<ul style="list-style-type: none"> • Layperson, non-professional health care provider or non-clinical health care person 	<ul style="list-style-type: none"> • Health care professional 	<ul style="list-style-type: none"> • Health care professional • Advanced practice 	<ul style="list-style-type: none"> • Non-clinical persons necessary for supporting caregiver functions
Educational / training needs	<ul style="list-style-type: none"> • Low-to-medium educational requirements for activities – training within minutes to few hours 	<ul style="list-style-type: none"> • Higher education requirements for activities – training within hours because of health care knowledge background 	<ul style="list-style-type: none"> • Higher education requirements for activities – training within hours because of health care knowledge background 	<ul style="list-style-type: none"> • Low-to-medium educational requirements for activities – training within minutes to few hours
Examples of Care Provider	<ul style="list-style-type: none"> • Volunteers • Nursing and medical students • Basic care providers • Respiratory therapists • Physiotherapists 	<ul style="list-style-type: none"> • LPNs • Paramedics • Retired medical professionals 	<ul style="list-style-type: none"> • Physician • RNs • Trauma nurse 	<ul style="list-style-type: none"> • Patient transporters • Food delivery staff • Housekeeping staff
Direct care	<ul style="list-style-type: none"> • Assistance with or provisions of activities of daily living (ADL) • Basic VS: HR, RR, automatic BP, T • Communicating information to ACP • Moving patients: mobilization, transport 	<ul style="list-style-type: none"> • Admission / discharge per established criteria • Assessment, history per checklists • Initiate standardize treatment protocols, diagnostic testing • Airway management • Oxygenation 	<ul style="list-style-type: none"> • Diagnosis of disease/disorder • Admission / discharge to various level of care (home ↔ ICU) • Assessment, history • Order & interpret diagnostic tests • Decision-making re: complex therapy 	<ul style="list-style-type: none"> • Direct care only provided in emergency situations

	Basic Care Provider	Advanced Care Provider	Decision/Disposition Care Provider	Support Services
	<ul style="list-style-type: none"> • Accessing and stocking equipment / supplies / laundry • Providing safe, clean environment • Preparation of body • Assisting advanced and directing care providers • Patient / family encouragement and support • Security 	<ul style="list-style-type: none"> • Chest therapy • Venipuncture, injections (immunization) • Circulatory support: IV • Medication administration • Monitoring: VS, ECG, vent. • Nutrition initiation • Urinary catheterization • Health teaching • Psychological support • CISM • Resuscitation • Pronouncing death (ILI) 	<p>requirements</p> <ul style="list-style-type: none"> • Higher risk invasive procedures (e.g. intubation, chest tube insertion) • Prescribe medications • Resuscitation • Certifying death (ILI) 	

ACS Supply Requirements and Considerations

In addition to human resources, alternative care sites will also have supply requirements, which will likely differ depending on whether they are being used solely for rapid screening and triage, or expanded ambulatory/supportive care. The following checklists are meant to provide guidance to frontline planners as they consider the services and supplies required to operate an alternative care site in their community.

Assessment Centre Checklist:

SERVICES	CONSIDERATIONS	AVAILABILITY	COMMENTS
Laundry services	<i>(Rolling carts for delivery/removal of linens)</i>		
Medical and solid waste removal	<i>Minimal - Biohazard bags</i>		
Building maintenance	<i>Minimal</i>		
Contracted security	<i>Priority</i>		
Delivery of oxygen	<i>(Minimal use)</i>		
Food services	<i>(Services for staff)</i>		
Fuel for generators			
Back-up generators			
GENERIC SUPPLIES	CONSIDERATIONS	ORDERED (✓)	COMMENTS
<i>Waiting Rooms</i>			
Chairs			
Tables			
Television(s) Screens	<i>For continuous loop education</i>		
<i>Administration Area</i>	CONSIDERATIONS	ORDERED (✓)	COMMENTS
Chairs			
Desk			
Lamp and/or other lighting			
Trash receptacles			
File cabinets			
Communications (telephone, fax, mobile phones, radios, and/or alternatives [for isolated communities])			
Patient Registration Area	<i>Computer/laptop/Meditech</i>		
Computers and Internet access			

Assessment Room	CONSIDERATIONS	ORDERED (✓)	COMMENTS
Examination tables	<i>(Per facility capacity)</i>		
Chairs			
Biohazard receptacles			
Trash receptacles			
Table paper			
Pillows			
Bags	<i>(Biohazard, trash, clothing, and specimen)</i>		
Antivirals and Discharge information			
Staff uniforms/smocks	<i>(Number per staff member?)</i>		
Refrigerator(s)	<i>For fluids /water</i>		
Portable oxygen			
Acute Transfer Area (two beds)	CONSIDERATIONS	ORDERED (✓)	COMMENTS
Minor surgical table			
Surgical light			
Oto/ophthalmoscope			
NIBP monitor			
Defibrillator			
2 beds / stretchers			
Wheelchairs			
Vital signs monitor			
Stand			
Trash receptacles			
Storage cabinets			
Soap dispenser			
Towel dispenser			
Sink and running water			
RESTROOMS	CONSIDERATIONS	ORDERED (✓)	COMMENTS
Curtains/room dividers			
Towel rack			
Bathroom amenities	<i>(Toilet paper, soap, paper towels, plungers)</i>		
Soap dispenser			

Towel dispenser			
Cleaning materials/disinfectants			
PPE			
Respirators and masks			
Gloves	<i>All sizes</i>		
Disposable Gowns	<i>Different colors for staff and patients</i>		
Face shields			

Limited Supportive Care or Expanded Ambulatory Care Facility:

SERVICES	CONSIDERATIONS	AVAILABLE	COMMENTS
Laundry services	<i>(Rolling carts for delivery/removal of linens)</i>		
Morgue	<i>(Reefer trucks or mortuary service)</i>		
Medical and solid waste removal			
Building maintenance			
Contract security			
Delivery of oxygen			
Food services	<i>(Services for patients and staff)</i>		
Fuel for generators			
Back-up generators			
SUPPLIES	CONSIDERATIONS	ORDERED (✓)	COMMENTS
Administration Area			
Chairs			
Desk			
Lamp and/or other lighting			
Trash receptacles			
File cabinets			
Communications (phones, fax, mobile phones, portable radios)			
Patient registration and identification tools			
Computers and Internet access			
Assessment Room			
Examination tables	<i>(Per facility capacity)</i>		
Chairs			
Biohazard receptacles			
Trash receptacles			
Table paper			
Pillows	<i>(Two per patient)</i>		
Bags	<i>(Biohazard, trash, clothing, and specimens)</i>		
Blocks	<i>(For placement at head or foot of beds)</i>		
Patient gowns			

Staff uniforms/smocks	<i>(Numbers per patient/staff</i>		
Portable storage units	<i>Secured for antivirals/records etc.</i>		
Refrigerator(s)	<i>Fluids/food</i>		
Portable oxygen			
<i>Patient Wards (30) patients</i>			
	CONSIDERATIONS	ORDERED (✓)	COMMENTS
Beds and bedding			
Curtains/room dividers	<i>(For palliative/commode/privacy)</i>		
Over the bed table			
Bedside furniture			
Chairs			
Lamps and/or additional lighting			
ER bags for personal items			
Tissues			
Vomit receptacles			
Trash receptacles			
<i>Resuscitation Area (two to three beds)</i>			
	CONSIDERATIONS	ORDERED (✓)	COMMENTS
Minor surgical table			
Surgical light			
Oto/ophthalmoscope			
NIBP monitor			
Defibrillator			
Vital signs monitor			
Stand			
Trash receptacles			
Portable suction			
Storage cabinets			
Soap dispenser			
Towel dispenser			
Sink and running water			
<i>Restrooms</i>			
	CONSIDERATIONS	ORDERED (✓)	COMMENTS
Curtains/room dividers			
Towel rack			
Bathroom amenities	<i>(Toilet paper, soap, paper towels, plungers)</i>		
Soap dispenser			
Hand-washing posters			
Towel dispenser			
Cleaning disinfectants			

AUXILIARY SERVICES			
Security			
Ground Transportation	Transfers to Acute or Home Pick-up		
Spiritual Aid Workers			
Social Work/Assistance			

Facility Screening and Evaluation

A facility checklist has also been developed for planners to aid them in the selection of facilities within their community that could be used in an ACS strategy. This evaluation is not exhaustive, but can act as a starting point for planners to begin considering the building requirements necessary to operate an alternative care site.

This facility assessment, developed in Excel format, can be found in **Appendix 5**.